Emerald Coast Pain Services
3997 Commons Drive, Suite M
Destin, FL 32541

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Emerald Coast Pain Services** to use and disclose protected health (PHI) about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by **Emerald Coast Pain Services** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Emerald Coast Pain Services** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Amy Bell** at **Emerald Coast Pain Services**, 3997 Commons Drive, Suite M, Destin, FL 32541.

With this consent, **Emerald Coast Pain Services** may call home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out the performance of their duty, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Emerald Coast Pain Services** may mail to my home or other alternative location any items that assist the practice in carrying out the performance of their duty, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Emerald Coast Pain Services** may e-mail to my home other alternative location any items that assist the practice in carrying out the performance of their duty, such as appointment reminder cards and patient statements. I have the right to request that **Emerald Coast Pain Services** restrict how it uses or discloses my PHI to carry out the performance of their duty. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Emerald Coast Pain Services** to use and disclose my PHI to carry out the performance of their duty.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Emerald Coast Pain Services** may decline to provide treatment to me.

______________________________ ______________________
Signature of Patient Date

______________________________ ______________________
Signature of Legal Guardian, if applicable (relationship) Date