NEUROMECHANICAL PAIN MANAGEMENT ASSOCIATES, P.C

8025 MILL CREEK PARKWAY LEVITTOWN, PA19054

OFFICE- 215-547-6660 FAX 215-946-6438

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patients Name: _____

Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

Address: _____

3. The type and amount of information to be used or disclosed is as follows:

- ☐ Problem list
- ☐ Medication list
- ☐ List of allergies
- ☐ Immunization record
- ☐ Most recent history
- ☐ Most recent discharge summary
- ☐ Laboratory results
- ☐ X-ray and imaging reports
- ☐ Consultation reports
- ☐ Entire record
- ☐ Other: _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome, (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:
   Neuromechanical Pain Management Associates, P.C
   Address: 8025 Mill Creek parkway Levittown, PA 19054
   For the purpose of: **HEALTH HISTORY**
6. I understand I have the right to revoke this authorization at any time, I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition_____. If I fail to specify a expiration date, event or condition, this authorization will expire in six months.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this from in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR164.524. I understand any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact **NEUROMECHANICAL PAIN MANAGEMENT ASSOCIATES, P.C**

Signature of patient or Legal representative _____ **Date** _____

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CONSENT FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I voluntarily consent to the Chiropractors of **Neuromechanical Pain Management Associates** For the evaluation and treatment of the conditions for which I present myself to this office.

I acknowledge that I am legally responsible for all reasonable charges in connection with the medical care and treatment provided by representatives of **Neuromechanical Pain Management Associates** and promise to pay whatever charges are not paid by my health plan or insurance in return for the medical care and services that are provided to the patient. I understand that this consent form will be valid and remain in effect as long as I receive my medical care at **Neuromechanical Pain Management Associates**. I understand that this consent may be revoked in writing at any time.

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

I hereby authorize my insurance benefits to be paid to **Neuromechanical Pain Management Associates,** realizing I am responsible to pay non-covered services. I certify that the information given by me to **Neuromechanical Pain Management Associates**, in applying for payment under insurance coverage or other protection is correct and complete. I authorize any holder of medical information about me, to release to the insurance company or its agents, any information needed to determine the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I GIVE MY CONSENT FOR TREATMENT AND AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ AND UNDERSTAND THIS INFORMATION.

_____

SIGNATURE OF PATIENT DATE