

LEHIGH VALLEY PAIN MANAGEMENT/TILGHMAN MEDICAL CENTER

CONSENT TO USE AND DISCLOSURE OF INFORMATION
FOR TREATMENT PAYMENT OR OPERATIONS

I hereby consent to the use and disclosure of information in my medical records for treatment, payment and health care operations purpose: I understand that this consent is voluntary. I understand that information in my medical records may be used and disclosed to persons other than Lehigh Valley Pain Management/Tilghman Medical Center to carry out their responsibilities in connection to my medical health care treatment, in payment for health care services rendered to me and in activities related to health care operations.

Initials: _____

I understand that additional information on Lehigh Valley Pain Management/Tilghman Medical Center privacy practices related to my medical record is available from the Lehigh Valley Pain Management/Tilghman Medical Center's Notice of Privacy Practices, a copy of which has been-made available to me, and which I have read or do not wish to read, prior to signing this consent.

Initials: _____

I understand that changes in Lehigh Valley Pain Management/Tilghman Medical Center privacy practices will result in modifications to the Notice of Privacy Practices and that up-to-date notices will be available at the reception desk of Lehigh Valley Pain Management /Tilghman Medical Center at 4825 Tilghman Street, Allentown PA 18104.

Initials: _____

I understand that I may request Lehigh Valley Pain Management/Tilghman medical Center to restrict how or to whom my medical records are used or disclosed, but that Lehigh Valley Pain Management/Tilghman Medical Center may refuse the restrictions I request. However if Lehigh Valley Pain Management/Tilghman Medical Center agrees to the restrictions, it is bound to them when disclosing information in my medical records.

Initials: _____

I understand that I can revoke this consent at any time, by notifying Lehigh Valley Pain Management/Tilghman Medical Center in writing, but if I do, it won't have any effect on actions Lehigh Valley Pain management/Tilghman Medical Center took before they received the notification.

Initials: _____

I understand that this consent applies to the use and disclosure of information for treatment, payment or operations purposes only and that Lehigh Valley Pain Management/Tilghman Medical Center may decline to provide medical health care services to me if I do not sign it.

Initials: _____

Signature of Patient or Patient's Representative

Date

Printed Name of Patient's Representative _____

Relationship to Patient: _____