Advanced Pain Diagnostic & Solutions requests that you, _____ provide
Patient Name
consent to release confidential healthcare information to those entities responsible for paying for your medical care, authorizing treatment, and/or managing the other operational components related to delivering your healthcare.

CONDITIONS:

- The patient understands that his/her healthcare information is to be used for treatment, payment or for healthcare operations.
- The patient understands that his/her healthcare information may be disclosed to other healthcare providers for the purposes of treatment, payment or for healthcare operations.
- The healthcare organization reserves the right to either honor or dismiss the patient's request to limit the use of the patient's healthcare information.
- This consent is between:
  Advanced Pain Diagnostic & Solutions and _____
  Patient Name
- This consent can be revoked; however, the request must be in writing.
- Additional information can be obtained by reading the organization's Privacy Notice.
- This consent form will be maintained by this organization for a period of six (6) years.

SIGNATURES:

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

(original to be placed in patient's medical record)