PAIN MANAGEMENT TREATMENT AGREEMENT

When other pain management treatment options are unavailable or have proven ineffective, opioid (narcotic) medications may be considered to improve quality of life, as well as the ability to function and work. While all medications have possible side effects, opioid medications are potentially more dangerous with respect to side effects and/or risks. To ensure safe usage and pain control, proper monitoring through drug testing is required. The following stipulations are mandatory for all patients to receive pain management treatment at the Institute.

NON-COMPLIANCE WITH ANY ONE OF THESE CONDITIONS MAY RESULT IN DISCHARGE FROM THE PRACTICE.

POTENTIAL SIDE EFFECTS OF OPIOID (NARCOTIC) MEDICATIONS:

The following list includes the most common, but not all, side effects associated with the use of opioid medications:

- Addiction (cessation triggers withdrawal symptoms such as increased pain, agitation, nausea, diarrhea)
- Appetite decrease or loss
- Balance and/or co-ordination disruption
- Confusion and/or difficulty thinking, concentrating, focusing clearly
- Constipation
- Increased drowsiness/sleepiness
- Respiratory depression (breathing too slowly)
- Psychological dependence (cessation triggers craving/depression)
- Tolerance (pseudo-addiction; increased amounts of a medication are needed to control pain)

PATIENTS RECEIVING OPIOID (NARCOTIC) TREATMENT MUST AGREE TO ALL OF THE FOLLOWING:

- **I WILL OBTAIN *ALL* PRESCRIPTIONS FOR OPIOIDS (NARCOTICS) *ONLY* FROM LOUISIANA SPINE AND PAIN INSTITUTE (LSPI).**
- **I WILL USE *ONLY ONE PHARMACY* TO FILL OPIOID PRESCRIPTIONS: ______________________________.**
- **I WILL IMMEDIATELY NOTIFY MY LSPI PHYSICIAN IF FOR ANY REASON ANOTHER PHARMACY IS USED.**
- **I WILL *TAKE ALL MEDICATIONS* PRESCRIBED BY MY LSPI PHYSICIAN *ONLY AS DIRECTED*.**
- **I WILL NOT *SHARE, GIVE, ALLOW OTHERS TO CONSUME OR PHYSICALLY REMOVE* MY MEDICATIONS.**
- **I UNDERSTAND THAT LSPI DOES *NOT* REPLACE LOST OR STOLEN OPIOID (NARCOTIC) PRESCRIPTIONS/MEDICATIONS.**
- **I WILL NOT ACCEPT ANY PAIN MEDICATION FROM ANOTHER PHYSICIAN.**
- **I WILL NOTIFIY ANY/ALL OTHER PHYSICIANS OF MY OPIOID TREATMENT PRESCRIBED BY MY LSPI PHYCISIAN.**
- **I WILL NOT SEEK EMERGENCY TREATMENT FOR THE CHRONIC PAIN CONDITION MY LSPI PHYSICIAN IS TREATING.**
- **I WILL IMMEDIATELY NOTIFY MY LSPI PHYSICIAN IF I RECEIVE EMERGENCY/OTHER MEDICAL TREATMENT FOR ANOTHER REASON.**
- **I WILL KEEP ALL OFFICE APPOINTMENTS. OPIOID PRESCRIPTIONS ARE NOT REFILLED WITHOUT AN OFFICE VISIT AND I MAY EXPERIENCE MEDICATION WITHDRAWAL SYMPTOMS IF I MISS MY APPOINTMENT.**
- **I WILL ACTIVELY PATICIPATE IN OTHER, ADDITIONAL PAIN THERAPIES AS RECOMMENDED BY MY PHYSICIAN.**
- **I ACCEPT RESPONSIBILITY TO GRADUALLY INCREASE MY DAILY ACTIVITIES AS RECOMMENDED BY MY PHYSICIAN.**
- **I DO NOT NOW, NOR HAVE I EVER, HAD A PROBLEM WITH SUBSTANCE ABUSE OR MEDICATION DEPENDENCE**
- **I AM NOT PREGNANT; HOWEVER, I WILL NOTIFY MY LSPI PHYSICIAN IMMEDIATELY IF I BECOME PREGNANT.**
- **I UNDERSTAND I WILL BE SUBJECT TO RANDOM DRUG TESTING AND RANDOM PILL COUNTS. IF I REFUSE MY LSPI PHYSICIAN HAS THE RIGHT TO WITHHOLD ANY/ALL MEDICATION, AS WELL AS DISCHARGE ME FROM THE PRACTICE.**
- **I WILL BE COURTEOUS AND RESPECTFUL TO OFFICE STAFF AND OTHERS**

OPIOID TREATMENT WILL BE DISCONTINUED IF ANY OF THE FOLLOWING OCCUR:

- **MY LSPI PHYSICIAN FELLS THAT OPIOIDS ARE INEFFECTIVE IN RELIEVING MY PAIN OR IMPROVING MY FUNCTIONALITY.**
- **I VIOLATE THIS AGREEMENT BY SHARING/GIVING/SELLING/LOSING MY MEDICATIONS, OR ALLOWING THEM TO BE STOLEN.**
- **I FAIL TO TAKE MY MEDICATIONS AS DIRECTED.**
- **I OBTAIN OPIOID MEDICATIONS FROM SOURCES OTHER THAN MY LSPI PHYSICIAN.**
- **I ABUSE OTHER SUBSTANCES, LEGAL OR ILLEGAL (ALCOHOL, COCAINE, MARIJUANNA, NARCOTICS, ETC).**
- **IF ANOTHER CONDITION ARISES THAT PROHIBITS/ CONTRAINDICATES CONTINUING OPIOID TREATMENT.**

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PRESCRIPTION REFILL POLICY

- **OPIOID PRESCRIPTION REFILLS ARE AVAILABLE ONLY THROUGH A SCHEDULED VISIT DURING REGULAR OFFICE HOURS, (MONDAY-FRIDAY, 8:00 A.M. TO 5:00 P.M.).**
- **IT IS MY RESPONSIBILITY TO PLAN AHEAD AND ARRIVE FOR OFFICE VISITS AS SCHEDULED AND TAKE MY MEDICATIONS AS DIRECTED TO PREVENT RUNNING SHORT OF MEDICATION BEFORE MY NEXT APPOINTMENT.**

AUTHORIZATION AND CONSENT

I consent for my LSPI physician and office staff to communicate directly with my pharmacy or other organizations to obtain information regarding my prescription history. I agree to waive any applicable privilege or right of confidentiality with respect to the prescribing of my pain medication. I authorize my LSPI physician and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the Louisiana Board of Pharmacy, in the investigation of my possible misuse, sale, or diversion of my pain medication. I authorize a copy of this agreement to be provided to my pharmacy and other health care providers as needed.

I understand that the random drug screen testing results may be released to my other healthcare providers, insurance company, or other reimbursing agencies. I also authorize any other healthcare provider, pharmacy, and law enforcement or judiciary body to release any pertinent information regarding my prescriptions or urine/blood drug screen testing results.

My failure to follow the Treatment Plan as outlined by my LSPI physician indicates I no longer agree with the Treatment Plan and will result in my being discharged from the practice.

If I refuse to sign the treatment agreement, I understand that I WILL NOT be treated for pain management at Louisiana Spine and Pain Institute

Termination Clauses

My LSPI physician may terminate this agreement at any time if he/she believes 1) I am not complying with its terms, 2) if I have made a material misrepresentation or false statement concerning my pain or 3) falsely states my compliance with the terms of this agreement.

The patient may terminate this agreement at any time.

If this agreement is terminated, the doctor/patient relationship is terminated and the patient will be formally discharged from the facility. Thus, the patient cannot and will not be treated by another physician associated with the practice.

I, the undersigned, attest that the above agreement was discussed with me, and I fully understand and agree to ALL of the conditions, requirements and instructions. I also understand that failure to comply with the above may result in my discharge from this practice.

Patient Name:____________________ **(Please Print) Date:** ____/____/20____

Patient/ Guardian Signature: ________________ **Witness Signature:** ________________

Authorization for Treatment

I hereby authorize the physician(s) of the Louisiana Spine and Pain Institute to disclose any or all of the information in my records to any person, corporation or agency which is or may be liable for all or part of the Louisiana Spina and Pain Institute's charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the health maintenance organizations, preferred provider organizations, worker's compensation carriers, welfare funds, the social security administration or it's intermediaries or carriers. I understand that my medical records may contain hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus (HIV), also known as acquired immune deficiency syndrome (AIDS). With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning my identity and release the Louisiana Spine and Pain Institute, its agents, and its employees from liability in connection with the release of information contained therein.

Patient/ Guardian Signature:____________________

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New Patient Intake form

Name: ______________________________ **Date:** ____________________

Primary Care Physician: ____________________ **Referring Physician:** ____________________

Please list all Medications you are currently taking (including dosage)

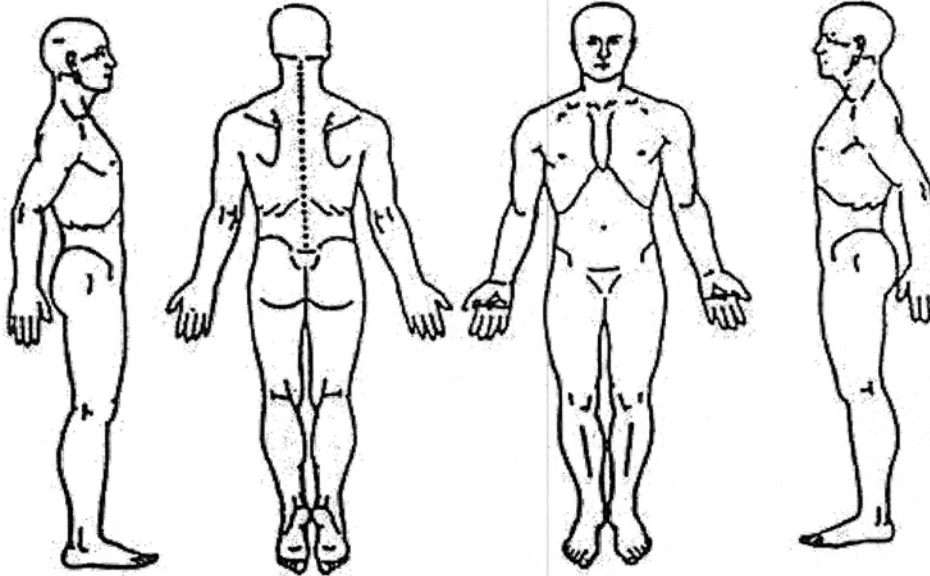
______________________ ______________________

______________________ ______________________

______________________ ______________________

Please circle if you take Coumadin, Warfarin, Plavix, Lovonox or Asprin. If Yes, last dose? __________

Shade the areas in which you have pain:



Characteristics of your pain:

Pain intensity (0= no pain, 10= worst pain ever)

Please list number that best describes your pain

I do not have any other symptoms

Average pain ______

Worst pain ______

With activity ______

Associated Systems, please circle if applies to you

Fatigue

Loss of bladder/bowel control

Nausea

Numbness

Tingling, burning or pricking feeling

Spasm or Weakness

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Circle activities that make pain worse:

All activities
Bending forward
Exertion/ Exercise
Getting out of chair
Lifting
Lying down
Moderate Physical Activity
Nonspecific activity
Position change
Reaching
Significant Physical Activity
Sitting
Standing
Turning the head
Twisting
Walking
Other: ____________________________

Circle activities that make pain better:

None
Bending forward
Injections
Lying down
Medications
Moving
Position change
Physical activity
Procedures
Rest
Sitting
Standing
Other: __________________________

Circle the qualities of your pain:

Aching
Burning
Dull
Sharp
Shooting
Stabbing
Throbbing
Pressure
Crushing
Cramping
Spasmodic
Pulling
Tender
Tight
Knife like
Hot
Sore

Circle the duration of you pain:

Constant
Intermittent

If you are allergic to anything please list below:

____

____

____

____

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Circle any conditions you have:

Headaches	Gallstones	Hepatitis	Bladder Cancer
Migraines	GERD	HIV	Breast Cancer
Seasonal Allergies	GI Bleed	Shingles	Colon Cancer
Sinusitis	Hiatal Hernia		Lung Cancer
	Irritable Bowel Syndrome	Stroke	Melanoma
Angina	Pancreatitis	Parkinson's Disease	Prostate Cancer
Arrhythmia	Ulcers	Seizure Disorder	
Coronary Artery Disease		TIA	Back Pain
Deep Venous Thrombosis			Connective Tissue Disorder
High Blood Pressure	Enlarged Prostate	ADD	Fibromyalgia
High Cholesterol	Frequent Bladder Infections	Anxiety	Kyphoscoliosis
Past Heart Attach	Kidney Stones	Bipolar Disorder	Osteoarthritis
Mitral Valve Prolapse	Renal Failure	Dementia	Osteoporosis
Heart Murmur	Renal Insufficiency	Depression	Rheumatoid Arthritis
Pacemaker		Schizophrenia	Scoliosis
Peripheral Vascular Disease			
Asthma	Diabetes	Anemia	
COPD	Obesity	Bleeding Disorder	
Obstructive Sleep Apnea	Thyroid Disease	Transfusions	

List all past surgeries followed by approximate dates:

1. ____________________ __________
2. ____________________ __________
3. ____________________ __________
4. ____________________ __________
5. ____________________ __________
6. ____________________ __________
7. ____________________ __________
8. ____________________ __________
9. ____________________ __________
10. ____________________ __________

Circle Prior Treatments:

	"X" if it was helpful	Details
Acupuncture	______	____________________
Biofeedback Relaxation Therapy	______	____________________
Botox Injections	______	____________________
Chiropractic	______	____________________
Heat	______	____________________
Home Exercise	______	____________________
Ice	______	____________________
Massage	______	____________________
Minimally Invasive Procedures	______	____________________
Occupational Therapy	______	____________________
Physical Therapy	______	____________________
Surgery	______	____________________
TENS	______	____________________

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Circle all medication taken for your pain in the past:

Medication	"X" if it helped	Details
NSAIDS	______	______
Celebrex	______	______
Diclofenac	______	______
Flector Patch	______	______
Ibuprofen	______	______
Mobic	______	______
Nabumetone	______	______
Naproxen	______	______
Voltaren gel	______	______
Flexeril	______	______
Skelaxin	______	______
Soma	______	______
Zanaflex	______	______
Actiq	______	______
Hydrocodone	______	______
Hydromorphone	______	______
Percocet	______	______
Duragesic	______	______
Methadone	______	______
Morphine	______	______
Oxycontin	______	______
Oxymorphine	______	______
Cymbalta	______	______
Lyrica	______	______
Neurontin	______	______
Savella	______	______
Topamax	______	______
Trileptal	______	______
Lidoderm Patch	______	______
Tramadol	______	______
Tylenol	______	______
Blood thinners	______	______
Other Medications:	______	______
______	______	______
______	______	______

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Circle what applies:

Single
Married
Domestic Partner
Widowed
Separated
Divorced

Number of Children _______
Ages of Children _______

Retired
Disabled
Unemployed
Self-employed
Employed Part Time
Employed Full Time
Current Occupation ____________
Previous Occupation____________

Circle Highest Level of Education
Elementary Education
Some High School
High School Diploma
GED
Some College
College Degree
Master's Degree
Doctorate Degree

Currently smoke every day
Currently smoke some days
Former Smoker
Never Smoker
Cigarette Packs per day _______
Cigars per day _______
Pipe times per day _______
Chew cans per day _______
Total Years _______

No Alcohol Use
Rarely Use Alcohol
Socially Use Alcohol
Daily Use Alcohol
Details______________

I do not use recreational drugs
I use Marijuana
I use Cocaine
I use Heroine
I use Morphine
I use Methamphetamines
I use LSD
I use Mushrooms
I use Ecstasy
I use ________________________

I never exercise
I exercise 1-2 times per week
I exercise 3-5 times per week
I exercise 6-7 times per week
Type of Exercise I do:
Aerobics
Biking
Running
Hiking
Swimming
Climbing
Treadmill/Elliptical
Walking
Weight Lifting
Other __________________

Family History place an "X" if this relative has the following:

	Father	Mother	Sister	Brother	Other
Arthritis	______	______	______	______	______
Asthma	______	______	______	______	______
Bleeding Disorder	______	______	______	______	______
Coronary Artery Disease	______	______	______	______	______
Cancer	______	______	______	______	______
Congestive Heart Failure	______	______	______	______	______
COPD	______	______	______	______	______
Diabetes	______	______	______	______	______
High Blood Pressure	______	______	______	______	______
Irritable Bowel Syndrome	______	______	______	______	______
Kidney Disease	______	______	______	______	______
Heart Attack	______	______	______	______	______
Peripheral Artery Disease	______	______	______	______	______
Stroke	______	______	______	______	______
Thyroid Disease	______	______	______	______	______
Other	______	______	______	______	______

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Circle if you have the following:

Depression Describe: ______________________________

Anxiety Describe: ______________________________

Psychosis Describe: ______________________________

Circle what applies:

I am currently not in treatment
I am currently seeing a psychiatrist
I am currently seeing a psychologist

I have had thoughts of suicide
I have not had thoughts of suicide

I am coping with my chronic pain
I am frustrated with my chronic pain

Circle all that apply to you:

Fever
Chills
Fatigue
Poor Appetite
Weight Gain
Weight Loss

Hearing Loss
Sore Throat
Blurred Vision
Decreased Vision

Shortness of Breath
Wheezing
Cough

Chest pain
Irregular Heart Beats
Swelling in Leg

Rash
Itching
Lesions
Bruise Easily

Joint Pain
Joint Swelling
Stiffness
Weakness

Abdominal Pain
Nausea
Vomiting
Diarrhea
Heartburn
Consipation

Sexual Problems
Problems Urinating

Headaches
Dizziness
Loss of Consciousness
Weakness
Numbness
Tingling

Depression
Anxiety

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NAME (last, first, middle): ____ TITLE: ____________

HOME ADDRESS: ____

PREFERRED NAME: _________________________ SS#: ______-______-_______ DOB: ____/____/_____

HOME PHONE: _______________ WORK PHONE: ________________ CELL PHONE: __________________

EMAIL ADDRESS: ____

WHOM MAY WE THANK FOR THIS REFERRAL? ____

MEDIAL ALERTS: ____

DO YOU HAVE AN ADVANCE DIRECTIVE? (PLEASE CIRCLE ONE) YES NO or DNR

IS YOUR PAIN A RESULT OF A MOTOR VEHICLE ACCIDENT? (PLEASE CIRCLE ONE) YES or NO

ARE YOU CURRENTLY INVOLVED IN A LAWSUIT REGARDING YOUR CURRENT PAIN? YES or NO

EXPLAIN: ____

PRIMARY INSURANCE COVERAGE

SUBSCRIBER NAME: ______________________ RELATIONSHIP TO PATIENT: _________________________

SUBSCRIBER ADDRESS: ____

SS# ________-_______-________ EMPLOYER: ____

DOB: _______/_______/______ ADDRESS: ____

INSURANCE CO: __________________________________ ID#: __________________________________

ADDRESS: ____ GROUP: _________________________

SECONDARY INSURANCE COVERAGE

SUBSCRIBER NAME: ______________________ RELATIONSHIP TO PATIENT: _________________________

SUBSCRIBER ADDRESS: ____

SS# ________-_______-________ EMPLOYER: ____

DOB: _______/_______/______ ADDRESS: ____

INSURANCE CO: __________________________________ ID#: __________________________________

ADDRESS: ____ GROUP: _________________________

I understand that I am financially responsible for payment of this account and/or charges not covered by my insurance.

PATIENT SIGNATURE: ____ **DATE:** __________________

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EXPLANATION OF HIPAA

The Health Insurance Portability and Accountability Act of 1966 (HIPAA) requires an Authorization to Release Medical Information in order for health care providers to release medical information or records. New requirements for authorizations became effective April 16, 2003. This requirements also extends to organizations closely associated with health care providers, and their contractors. It is necessary to use this form when requesting information from health care providers because this law requires specific information to be provided on an authorization. This form should not be used to request records not covered by HIPAA (records obtained from a source other than a health care provider).

Medical Providers are mandated to protect information and to require the use of forms that comply with the law. This form complies with the requirements of HIPAA and should be accepted by all medical providers. However, if a medical provider insists that the provider's form be used, you may want to use that form if it will expedite the process of obtaining records. Please notify the AWPPW if this situation arises so that the problem can be resolved.

Requirements for using this form:

HIPAA also requires specific steps in obtaining and utilizing an authorization to release medical information. Therefore, it will be necessary that you:

- **Utilize one form for each medical provider from whom records are requested.**
- **Complete the forms in their entirety before asking a client to sign.**
- **Date the form at the time it is signed.**
- **Provide a copy of each completed form to the client.**

Note on records authorized to be released

All types of notes that you may need to request at any time from a particular provider should be checked. Otherwise, you may need to have another authorization signed before requesting additional records. There may be additional issues with some particular types of records.

- **Records related to HIV status may not be released unless the individual has signed a separate release specific to HIV related information. 5 U.S.C. §19203-D.**
- **Psychotherapy notes may not be released unless the individual has signed a separate release specifying that such notes may be released. 45 C.F.R. §164.508(b)(3)(ii)**
- **You must specify on the authorization the extent or nature of records to be released for drug or alcohol records. 42 U.S.C. 290dd-3; 42 U.S.C. 290ee-3; 42 C.F.R., Part 2. The individual may also use this section to limit other records to be released.**
- **'Medication administration logs…' relates to information that is not part of an individual's medical record. Such information that is not a part of an abuse/neglect investigations but must be specifically requested and have other patients' information redacted. This is time-consuming and costly, and such records should only be requested if necessary to investigate the specific allegations or serious incident.**

Note on statement of purpose

This statement of purpose should reflect the reason for the request. The client my elect to check the last statement 'other activities at the request of the individual' if desired.

Note on patient representatives

If patient's representative is signing the authorization, you must specify the relationship of the representative to the patient. Common relationships include:

- Parent or Guardian
- Conservator (a copy of the order appointing the conservator should also be provided)
- Attorney-in-fact (a copy of the notarized Power of Attorney should also be provided)
- Administrator of an Estate (a copy of the letters of administration from the court should also be provided)

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Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment, of my bills or in the performance of Ayman Hamed M.D.'s health care operations. The Notice of Privacy Practices is posted at the front desk and on our website at www.hamedmd.com.

Ayman Hamed, M.D. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of next appointment, or accessing Ayman Hamed, M.D.'s website.

____
Signature of Patient or Personal Representative

____
Name of Patient or Personal Representative (print)

____
Date

____
Description of Personal Representative's Authority

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ASSIGNMENT OF BENEFITS FORM

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance(s) carriers, including Medicare, private insurance and any other health/medical plan, to issue payment check(s) to Dr. Ayman Hamed, M.D. medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Dr. Ayman Hamed to (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Ayman Hamed on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that all fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this agreement is to be considered as valid as the original.

______________________________ ____________________

Patient/Responsible Party Signature Date

______________________________ ____________________

Witness Date

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SOAPP® VERSION 1.0-14Q

Name:____ Date: _________________________

The following are some questions given to all patients at the Pain Management center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine you treatment. Thank you.

Please answer the questions below using the following scale:

0= Never, 1= Seldom, 2= Sometimes, 3= Often, 4= Very Often

1. How often do toy have mood swings? 0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4
3. How often have any of your family members, including patents and grandparents, had a problem with alcohol or drugs? 0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs? 0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem? 0 1 2 3 4
6. How often have you attended an AA or NA meeting? 0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem? 0 1 2 3 4
9. How often have your medications been lost or stolen? 0 1 2 3 4
10. How often have others expressed concern over your use of medications? 0 1 2 3 4

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OPIOID RISK TOOL

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16-45 years	1	1
Psychological disease		
ADD, OCD, Bipolar, Schizophrenia	2	2
Depression	1	1
Scoring totals		

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (LAST, FIRST) ______________________ DOB ______________________

ADDRESS ______________________ SSN ______________________

CITY ______________ STATE ______________ ZIP ______________

PROVIDER/FACILITY AUTHORIZED TO RELEASE PHI	ENTITY RECEIVING THE PHI
NAME	NAME LOUISIANA SPINE AND PAIN INSTITUTE
ADDRESS	ADDRESS 4600 SHERWOOD COMMON BLVD., STE. 401
CITY	CITY BATON ROUGE
STATE ZIP	STATE LA ZIP 70816
PHONE FAX	PHONE 225-767-1390 FAX 225-767-1391

The Purpose of this Authorization is indicated in the box(es) below. (Place an "X" in the box(es) that apply.)

- ☐ Changing Physicians
- ☐ Legal Representation
- ☐ Continued Care
- ☐ Other activities at the request of the individual
- ☐ Investigating allegations of abuse

I authorize the release of the following protected health information. (Place an "X" in the box(es) that apply to the information you want released od you want to obtain.)

☐ Entire Record ☐ Office Notes ☐ Outpatient Records ☐ Surgical Reports ☐ Prescription Reports

☐ Laboratory Reports ☐ Radiological Imaging Reports

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records:

☐ Alcoholism ☐ Drug abuse ☐ Mental Health ☐ Vocational rehabilitation ☐ HIV (AIDS)

☐ Sexually Transmitted Diseases ☐ Other ______________________

This authorization will expire on the following date or event. If date or event is not indicated, authorization will expire within 12 months from date signed.

Date:______________ Event: ______________________

I UNDERSTAND THAT

1. I AM NOT REQUIRED TO SIGN THIS AUTHORIZATION AND THAT IS STRICTLY VOLUNTARY.
2. MY TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.
3. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING TO THE PROVIDER AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION, BUT IF I DO, IT WILL NOT HAVE ANY EFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION.
4. IF THE RECIPIENT IS NOT HEALTH PLAN OR HEALTHCARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS AND MY BE REDISCLOSED
5. I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT

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Signature of Individual or Personal Representative authorized by law Date

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Personal Representative's Relationship to Patient