Authorization for Use or Disclosure of Information for Purposes Requested by Natural Pain Management and Wellness (3/03)

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer of Natural Pain Management and Wellness, at 6245 Sheridan Dr, suite 116, Williamsville, NY 14221. I understand that a revocation is not effective to the extent that Natural Pain Management and Wellness has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Natural Pain Management and Wellness will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights) and/or to refuse to sign this authorization. I understand that the use or disclosure requested under this authorization may result in direct or indirect remuneration from a third party.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____ _____

Date of Signing Description of Personal Representative's Authority