INTEGRATIVE PAIN SERVICES, P.A.

MARK S. WHITE, D.O.

4807 SPICEWOOD SPRINGS ROAD
BUILDING 1, SUITE 1235
AUSTIN, TEXAS 78759
(512) 795-9977 FAX: (512) 418-8445

FINANCIAL POLICIES – PLEASE READ CAREFULLY

Your appointment will be made *after* we have received any referral or authorization required by your insurance company. The new patient packet must be returned to our office at least 24 hours prior to your appointment. Please arrive 30 minutes prior to your appointment time. **If you do not arrive 30 minutes prior to your appointment or do not have your paperwork completed as requested above, your appointment may be rescheduled or cancelled.**

CANCELLATION POLICY

If you need to cancel, please do so 24 hours (one business day) in advance of your scheduled appointment time. This office reserves the right to charge a $50 fee for missing an appointment or canceling with less than one business day's notice. The purpose of this fee is to encourage our patients to take their appointments as seriously as we do. That time is reserved for you. If your appointment is not kept, other patients who may need same day visits or earlier appointments are obliged to wait longer than necessary.

NON-SUFFICIENT FUNDS FEE

There is a $25 fee for checks returned to our office for insufficient funds, closed account, etc. The $25 fee and the amount of the check must be paid with cash, cashier's check, credit card or money order. If three checks are returned, we will no longer accept checks as a payment method. We use Telecheck for electronic check deposits whenever possible to avoid returned checks.

PAYMENT POLICY

All payments are due at the time of service. This includes co-payments, deductibles, and any portion of your bill that is not covered by your health insurance carrier. Past due balances must be paid before additional services are provided unless payment arrangements have been made prior to your visit. If you need to make "payments" for services, our office utilizes Care Credit for this purpose. Please ask for an application. We will assist you in applying.

FINANCIAL RESPONSIBILITY AGREEMENT

I understand that the information given by my insurance company is "not a guarantee of payment". I understand that my insurance company may deny payment for certain procedures or treatments. These procedures and treatments may not be covered benefits or the insurance company may later decide that they were "not reasonable", "not medically necessary", or "experimental and investigational". If my insurance company denies payment on a procedure or treatment provided by Integrative Pain Services, P.A., I agree to be personally responsible for payment in full of all services rendered.

____

Patient/Guardian Signature **Date**

____

Printed Name

Patient Information Sheet

Please answer all questions completely. This information is necessary for us to properly identify you & handle all your insurance matters.

Patient Last Name: ______________________ First Name: ___________________ MI: _______
Physical Address: ____
City: _________________________________ State: __________________ Zip: ___________
Mailing Address: ____
City: _________________________________ State: __________________ Zip: __________
Home Phone: ________________ Work Phone: _______________ Mobile: ________________
Maiden Name: _______________________ DOB: ____________ SSN: ___________________
Marital Status: S ____M ____D ____W____ DL#______________________ State: __________
Sex: F___ M ___Race ___________ Ethnicity: Hispanic / Non-Hispanic / Withheld (circle one)
Email Address: _____________________________Preferred Language: __________________
Employer: ____
Employer Address: ____
In case of emergency please notify:
Name: ___________________________ Phone: ______________ Relationship: _____________
Primary Care Physician: ____ Phone: _____________
Referring Physician: ____Phone: _____________

Insurance Information

Please complete ALL of the insurance information below, even if you have given us a copy of your insurance card. All co-payments are to be paid PRIOR to seeing the physician.

Primary Insurance: ____ Phone: _____________
Address: _____________________________City/State: _____________________ Zip: ________
Name of Insured: ______________________ DOB: ____________ SSN: ___________________
Relationship to patient: Self _______ Spouse ______ Child ______ Other ___________
Policy Holder's Employer: _____________________________ Retired: Yes _____ No _______
Member ID#: __________________________ Group#: _______________ Plan:___________
Secondary Insurance: ____ Phone: ____________
Address: _____________________________City/State: _____________________ Zip: ________
Name of Insured: ______________________ DOB: ______________ SSN: __________________
Relationship to patient: Self _______ Spouse _______ Child ______ Other ____________
Policy Holder's Employer: ______________________________ Retired: Yes _____ No ______
Member ID#: __________________________ Group#: ________________ Plan:___________

PLEASE READ CAREFULLY BEFORE SIGNING

I hereby authorize payment of medical benefits from my insurance companies to be paid directly to Integrative Pain Services, P.A. or Mark S. White, DO. I also authorize the release of medical information necessary to secure payment from my insurance carrier or other third party. I understand that I am fully responsible for all charges accumulated while under the care of the physician, regardless of insurance, and that full payment is due at the time of service unless I have made PRIOR arrangements.

____ ___________________________________

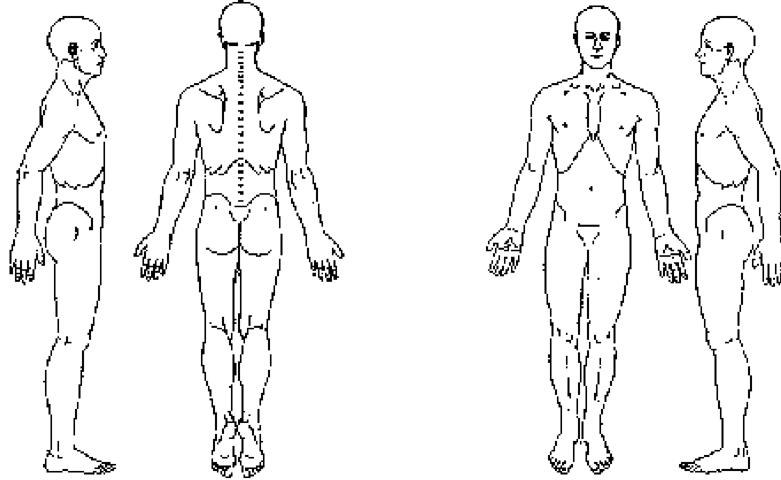
Patient or Legal Guardian's Signature Date

PAIN QUESTIONNAIRE

Date: _____________ Name:____

First Middle Last

Please ***shade*** the area(s) where you feel pain on the diagram below. Place an **X** on the areas that hurt the most.



Which of the following have been adversely affected by your painful condition?

- ❑ Activities of daily living
- ❑ Sleep
- ❑ Normal lifestyle
- ❑ Work activities

When did you first notice the pain? (Please fill in the blank with the approximate number of days, weeks, etc.)

_________ days ago
_________ weeks ago
_________ months ago
_________ years ago

What is your chief complaint? Check the main reason you are coming to the pain clinic:

- ❑ Headaches
- ❑ Neck Pain
- ❑ Shoulder Pain
- ❑ Upper Extremity Pain
- ❑ Upper Back Pain
- ❑ Chest Wall Pain
- ❑ Low Back Pain
- ❑ Hip Pain
- ❑ Lower Extremity Pain
- ❑ Abdominal Wall Pain
- ❑ Abdominal Pain
- ❑ Groin Pain
- ❑ Arthritis
- ❑ Fibromyalgia
- ❑ Pelvic Pain
- ❑ Other_________________

What side is your pain mainly on?

❑ Left side ❑ Right side ❑ Both sides ❑ In the middle

Does your pain radiate anywhere?

❑ Yes ❑ No

❑ Where? ____

When is your pain the worst?

- ❑ In the morning
- ❑ Progresses during the day
- ❑ At night
- ❑ Various times during the day

How would you describe the character or quality of your pain? (check all that apply)

- ❑ Throbbing
- ❑ Shooting
- ❑ Stabbing
- ❑ Sharp
- ❑ Cramping
- ❑ Gnawing
- ❑ Hot-Burning
- ❑ Aching
- ❑ Heavy
- ❑ Tender
- ❑ Splitting
- ❑ Tiring-Exhausting
- ❑ Sickening
- ❑ Fearful
- ❑ Punishing-Cruel

Please rate the severity of your pain:

- ❑ No Pain
- ❑ Mild
- ❑ Discomforting
- ❑ Distressing
- ❑ Horrible
- ❑ Excruciating

On a scale of 0 to 10 (please see below for description of ratings):

What is your ***lowest*** level of pain? (Circle #)	0	1	2	3	4	5	6	7	8	9	10
What is your ***average*** level of pain? (Circle #)	0	1	2	3	4	5	6	7	8	9	10
What is your ***highest*** level of pain? (Circle #)	0	1	2	3	4	5	6	7	8	9	10

0 – Pain free

1 – Very minor annoyance, occasional minor twinges. No medication needed.

2 – Minor annoyance, occasional strong twinges. No medication needed.

3 – Annoying enough to be distracting. Occasional mild pain medications take care of it (i.e. Tylenol, aspirin, ibuprofen).

4 – Can be ignored if you are really involved in work, but still distracting. Mild pain meds provide 3-4 hours of complete relief.

5 – Cannot be ignored for more than 30 minutes. Mild pain medications provide 3-4 hours of moderate relief.

6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities. Stronger pain medications reduce pain for 3-4 hours (i.e. Codeine, narcotics).

7 – Difficult to concentrate and interferes with sleep, but you can still function with effort. Stronger pain medications are only partially effective.

8 – Physical activity is severely limited. It takes effort to read and converse. Nausea and dizziness set in as factors of pain.

9 – Unable to speak, crying out or moaning uncontrollably – near delirium.

10 – Unconscious, pain causes you to pass out.

Under what circumstances did your pain begin? (Check one box.)

- ❑ Accident at work
- ❑ At work (not accident)
- ❑ Accident at home
- ❑ Motor vehicle accident
- ❑ Following surgery
- ❑ Following illness
- ❑ No apparent reason
- ❑ Other__________

What makes your pain worse? (Check all that apply)

- ❑ Bending or stooping
- ❑ Coughing or straining
- ❑ Driving
- ❑ Prolonged sitting
- ❑ Prolonged standing
- ❑ Lifting
- ❑ Lying down
- ❑ Weight bearing
- ❑ Physical activity
- ❑ Twisting
- ❑ Walking
- ❑ Walking Up/down stairs

If you have tried any of the treatments below please check each box that applies.

For any of the treatments that you checked Did it help or not?

Treatment	Helped	
❑ Epidural Steroid Injections	❑ Yes	❑ No
❑ Facet Injections	❑ Yes	❑ No
❑ Joint Injections	❑ Yes	❑ No
❑ Radiofrequency Nerve Destruction	❑ Yes	❑ No
❑ Trigger Point Injections	❑ Yes	❑ No
❑ Nerve blocks (injections)	❑ Yes	❑ No
❑ TENS (electrical stimulation)	❑ Yes	❑ No
❑ Biofeedback	❑ Yes	❑ No
❑ Acupuncture	❑ Yes	❑ No
❑ Manipulation	❑ Yes	❑ No
❑ Traction	❑ Yes	❑ No
❑ Physical therapy	❑ Yes	❑ No
❑ Massage therapy	❑ Yes	❑ No
❑ Psychotherapy/psychiatric care	❑ Yes	❑ No
❑ Hypnosis	❑ Yes	❑ No
❑ Exercise	❑ Yes	❑ No

If you take pain medication, does it…

❑ Relieve all or most all of your pain?
❑ Relieve about 75% of your pain?
❑ Relieve about 50% of your pain?
❑ Relieve about 25% of your pain?
❑ Relieve only a slight amount of pain?

For how long do you get relief after taking your pain medication? _______ hours

What side effects, if any, do you experience?

❑ Nausea
❑ Constipation
❑ Drowsiness
❑ Dizziness
❑ Confusion
❑ Heartburn
❑ Abdominal pain
❑ Dry mouth
❑ Other ______________________

Have you received treatment in the past by other pain management physicians? Yes __ No __ If so, who:

____

Have you received treatment for pain in the past by any other specialist physicians? Yes ___ No ___ If so, who:

____

Review of Systems: (Please mark if you are CURRENTLY experiencing any of the following conditions:)

Constitutional (general health):

❑ Chills
❑ Night Sweats
❑ Fatigue
❑ Unintentional weight gain
❑ Unintentional weight loss

Eyes:

❑ Blurred vision
❑ Eye pain
❑ Eye Drainage
❑ Glasses/contacts
❑ Aversion to light

Ears, Nose, Mouth, and Throat:

❑ Discharge of the ear
❑ Ear pain
❑ Ringing in ears
❑ Hearing problems
❑ Non-healing nasal ulcer
❑ Nosebleeds
❑ Nasal congestion
❑ Runny nose
❑ Soreness of tongue
❑ Periodontal disease
❑ Bleeding gums
❑ Dentures
❑ Sore throat
❑ Mouth ulcer
❑ Hoarseness
❑ Thrush
❑ Tooth pain

Cardiovascular:

- ❑ Chest pain
- ❑ Calf pain when walking
- ❑ Ankle edema
- ❑ Rapid heart beat
- ❑ Palpitations
- ❑ Dizziness
- ❑ Short of breath lying flat
- ❑ Varicose veins
- ❑ Awake with a sudden shortness of breath

Respiratory:

- ❑ Cough (acute)
- ❑ Cough (chronic)
- ❑ Shortness of breath
- ❑ Coughing blood
- ❑ Wheezing
- ❑ Tuberculosis exposure
- ❑ Pain of chest wall during breaths

Gastrointestinal:

- ❑ Abdominal pain
- ❑ Acid reflux
- ❑ Anorexia
- ❑ Difficulty swallowing
- ❑ Painful swallowing
- ❑ Vomiting blood
- ❑ Hemorrhoids
- ❑ Bloating
- ❑ Nausea
- ❑ Clay-colored stool
- ❑ Black, tarry stool
- ❑ Vomiting
- ❑ Heartburn
- ❑ Diarrhea
- ❑ Change in stool caliber
- ❑ Constipation
- ❑ Bright red blood from rectum

Genitourinary:

- ❑ Blood in urine
- ❑ Painful urination
- ❑ Genital lesions
- ❑ High-risk sexual behavior
- ❑ Unprotected intercourse
- ❑ Frequent UTIs
- ❑ Bladder incontinence
- ❑ Frequent urination during day
- ❑ Frequent urination at night
- ❑ Impotence

Musculoskeletal:

- ❑ Joint pain
- ❑ Back pain
- ❑ Joint stiffness
- ❑ Arm pain
- ❑ Leg pain
- ❑ Muscle pain

Integumentary/Breast:

- ❑ Acne
- ❑ Atypical moles
- ❑ Dry skin
- ❑ Fungal nail infection
- ❑ Jaundice
- ❑ Itchy skin
- ❑ Rashes
- ❑ Warts
- ❑ Breast mass
- ❑ Breast skin change
- ❑ Breast tenderness
- ❑ Nipple discharge

Neurological:

- ❑ Gait disturbance
- ❑ Tingling or numbness
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Memory loss
- ❑ Seizures
- ❑ Tremor
- ❑ Vertigo
- ❑ Weakness

Hematologic / Lymphatic:

- ❑ Excessive bleeding
- ❑ Easy bruising
- ❑ History of blood transfusion
- ❑ Enlarged lymph nodes

Endocrine:

- ❑ Change hand or feet size
- ❑ Excessive sweating
- ❑ Purple stretch marks on abdomen
- ❑ Hair loss
- ❑ Excessive hair loss
- ❑ Heat/cold intolerance
- ❑ Infertility
- ❑ Excessive thirst
- ❑ Excessive hunger
- ❑ Increased skin pigmentation

Allergic and Immunology:

- ❑ Seasonal allergies
- ❑ Perennial allergies
- ❑ Frequent upper respiratory illness
- ❑ HIV risk factors
- ❑ Hives

Psychiatric:

- ❑ Anxiety problems
- ❑ Depression symptoms
- ❑ Sleep disturbance
- ❑ Suicidal thoughts
- ❑ Crying spells
- ❑ Feeling stressed
- ❑ Loss of interest in pleasurable activities
- ❑ Personality change
- ❑ Poor concentration
- ❑ Recreational drug use
- ❑ Sadness

Past Medical History:

Please check any of the following **conditions** you have now or have had in the past:

❑ Seasonal allergies	❑ Bronchitis	❑ Cirrhosis	❑ Varicose veins/Phlebitis
❑ Anemia	❑ Emphysema	❑ Hepatitis A, B or C (Circle)	❑ Epilepsy
❑ Cancer, type?___________	❑ Pneumonia	❑ Pyelonephritis	❑ Migraine
❑ Diabetes	❑ Tuberculosis	❑ Urinary tract infection	❑ Headaches
❑ Gout	❑ Angina pectoris	❑ Kidney stones	❑ Anorexia or bulimia
❑ High cholesterol.	❑ Heart attack	❑ Kidney disease	❑ Preadolescent sexual abuse
❑ High blood pressure	❑ Atherosclerosis	❑ Sexually transmit. diseases	❑ Alcoholism, active
❑ HIV or AIDS (circle)	❑ Congestive heart failure	❑ Hemorrhoids	❑ Alcoholism, in recovery
❑ Mononucleosis	❑ Heart murmur	❑ Benign Prostate Swelling	❑ Drug addiction, active
❑ Glaucoma	❑ Rheumatic fever	❑ Prostatitis	❑ Drug addiction, in recovery
❑ Vision impairment	❑ Arrhythmias	❑ Menstrual disorder	❑ Anxiety
❑ Hearing impairment	❑ Pacemaker	❑ Ovarian cyst	❑ Depression
❑ Ear infections	❑ Hiatal hernia	❑ Fibrocystic breast disease	❑ Suicide attempt
❑ Goiter	❑ Peptic ulcer disease	❑ Osteoarthritis	❑ Bipolar disorder
❑ Hyperthyroidism	❑ Irritable bowel syndrome	❑ Rheumatoid arthritis	❑ Alzheimer's disease
❑ Hypothyroidism	❑ Constipation	❑ Arthritis, nonspecific	❑ Stroke
❑ Asthma	❑ Gall Stones	❑ Fractures	❑ ADHD or OCD

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Have you ever had a blood transfusion? ❑ Yes ❑ No

Past Surgical History:

Please place a check by any of the following **surgeries** if you have had them:

❑ Dental/oral surgery.	❑ Bladder Repair.	❑ Cataract removal
❑ Tonsillectomy.	❑ C-Section.	❑ Hip replacement right or left
❑ Thyroidectomy.	❑ Tubal Ligation.	❑ Knee arthroscopy right or left
❑ Carotid endarterectomy.	❑ D & C.	❑ Knee replacement right or left
❑ Coronary angioplasty.	❑ Hysterectomy.	❑ Surgical fracture repair.
❑ Coronary artery bypass graft.	❑ Ovarian Cystectomy.	❑ Lumbar laminectomy (back surgery).
❑ Lysis of abdominal adhesions.	❑ Breast biopsy.	❑ Lumbar laminectomy with fusion.
❑ Exploratory laparotomy.	❑ Mastectomy.	❑ Cervical laminectomy (neck surgery)
❑ Gall bladder surgery.	❑ Inguinal hernia repair	❑ Cervical fusion
❑ Appendectomy.	❑ Vasectomy.	
❑ Hemorrhoidectomy.	❑ TURP (prostate surgery).	
❑ Bladder cystoscopy.	❑ Skin cancer removal.	

Please list any other surgeries you have had:

____

____

____

Family History:

Please place a check by any diseases your relatives have had. If you are adopted and don't know your history, check here_______.

	FATHER	MOTHER
Age		
Good Health?		
Unknown	❑	❑
Deceased: age at death?	❑	❑
Allergies/Hay Fever	❑	❑
Anemia	❑	❑
Cancer	❑	❑
type?		
Diabetes (Type 1 or 2?)	❑	❑
Gout	❑	❑
High Cholesterol	❑	❑
Hypertension	❑	❑
Obesity	❑	❑
Glaucoma	❑	❑
Hearing Impairment	❑	❑
Thyroid Disease	❑	❑
Asthma	❑	❑
Emphysema	❑	❑
Tuberculosis	❑	❑
Early heart attack	❑	❑
Heart disease	❑	❑
Ulcers	❑	❑
Bowel Problems	❑	❑
Gallstones	❑	❑
Kidney Infections	❑	❑
Kidney Stones	❑	❑
Kidney Disease, Other	❑	❑
Prostate	❑	❑
Arthritis	❑	❑
Osteoporosis	❑	❑
Strokes	❑	❑
Epilepsy or Seizures	❑	❑
Migraine	❑	❑
Depression	❑	❑
Suicide	❑	❑
Mental Illness	❑	❑
Alcohol abuse	❑	❑
Illegal drug abuse	❑	❑
Prescription drug abuse	❑	❑
Alzheimer's	❑	❑

Social History:

What is your **marital status** now?

❑ Married ❑ Never married ❑ Divorced/separated ❑ Widowed

Number of children _____________

Do you drink **alcohol** (beer, wine, or liquor)?

❑ Not at all ❑ Occasional social drink ❑ About 1 to 3 drinks per day ❑ Four or more drinks per day

Do you now use, or have you ever used illegal drugs?

❑ Never used ❑ IV drugs _____ (still use) _____ (quit (when)) ❑ Marijuana _____ (still use) _____ (quit (when)) ❑ In recovery ____________ (how long?)

Have you ever abused or been addicted to prescription drugs?

❑ Never abused or addicted ❑ In recovery _______________ (how long?) ❑ Currently addicted

Do you use **tobacco**? If yes, for how long? ______________ years.

❑ Never ❑ Smoke _______ cigars per day ❑ Chews _______ pouches per week

❑ Smoke _______ cigarettes per day ❑ Smoke _______ pipefull(s) per day ❑ Dips ______ cans per week

Do you live in a house with a smoker? ❑ Yes ❑ No

What is your current occupation?

- ❑ Professional specialty (e.g., teacher, nurse)
- ❑ Executive, administrative, or managerial
- ❑ Technician or related support
- ❑ Sales-related
- ❑ Administrative or support occupation, including clerical
- ❑ Private household service
- ❑ Protective service occupation (e.g., police, fire)
- ❑ Service occupation, except protective or household
- ❑ Farming, forestry, or fishing-related
- ❑ Precision production, craft, or repair-related
- ❑ Construction relate
- ❑ Machine operator, assembler, or inspector (e.g., factory-worker)
- ❑ Transportation or material moving occupation (bus or truck driver)
- ❑ Handler, equipment cleaner, helper, or laborer
- ❑ Military
- ❑ Student
- ❑ Homemaker
- ❑ Vocational rehabilitation or job training
- ❑ Retired
- ❑ Disabled
- ❑ Other ____________________________

Specifically, what do you do at work? ____

Are you employed now?

- ❑ Yes – Full-time
- ❑ Yes – Full-time with restrictions
- ❑ Yes – Full-time, but on sick leave
- ❑ Yes – Part-time
- ❑ Yes – Part-time with restrictions
- ❑ Yes – Part-time, but on sick leave
- ❑ No – But not because of pain
- ❑ No – Unable to work or unemployed because of pain

Place of employment (if employed): ____

Has your job changed because of your painful condition? ❑ Yes ❑ No

If your job has changed as a result of your pain, what was your former occupation? ____________________________________

____

Since your pain began, has your income changed?

- ❑ No – It has stayed the same
- ❑ Yes – It has increased
- ❑ Yes – It has decreased slightly
- ❑ Yes – It has decreased moderately
- ❑ Yes – It has decreased greatly

Have you sued because of your pain in the past? ❑ Yes ❑ No

Are you suing now or do you plan to sue in the future because of your pain? ❑ Yes ❑ No

If so, for what? Check all that apply:

- ❑ Lost wages
- ❑ Payment of medical bills
- ❑ Payment for pain and suffering
- ❑ Other (describe): _________________________________

Have you received, or are you now receiving, any form of financial compensation for your pain? ❑ Yes ❑ No

If yes, please indicate the source(s) of payment:

- ❑ Worker's compensation
- ❑ Government disability
- ❑ Insurance or other commercial disability
- ❑ Accrued sick leave
- ❑ Accrued vacation leave
- ❑ Lump sum disbursement
- ❑ Other (describe): ___________________________

Have you had any CT, MRI or plain X-rays done related to this visit? CT MRI Plain Films

Where were these done? ____

When were these done? ____

Please include any comments you feel may be relevant in understanding the nature of your condition and how it has developed.
Please include any details about treatments from other physicians or practitioners if you feel they may aid us in helping you.

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Please list **<u>ALL</u>** medications you are currently taking including vitamins, supplements and over-the-counter medications.

Name of medication	Strength (mg)	Number of times per day
________________________	___________	_____________
________________________	___________	_____________
________________________	___________	_____________
________________________	___________	_____________
________________________	___________	_____________
________________________	___________	_____________
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________________________	___________	_____________
________________________	___________	_____________
________________________	___________	_____________
________________________	___________	_____________

Are you ***<u>allergic</u>*** to any ***medications or X-Ray contrast dye***? ☐ Yes ☐ No

If yes, please list: the drug(s) and the reaction(s):

Name of medication	Reaction symptoms
_________________	________________________________
_________________	________________________________
_________________	________________________________
_________________	________________________________

What pharmacy do you currently use? Name ____

Address & Phone number ____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
TO Integrative Pain Services, P.A./Mark S. White, D.O.

Patient Name ____

Date of Birth ________________________________ SS # ____________________________________(optional)

I authorize:

Name/Facility: ____

Address: ____

Phone: ___________________________________ Fax ______________________________________

To disclose health information TO:

Name: **Integrative Pain Services, P.A./Mark S. White, D.O.**

Address: **4807 Spicewood Springs Rd., Bldg. 1, Ste. 1235, Austin, TX 78759**

Phone: **(512) 795-9977** Fax: **(512) 418-8445**

Please release the following records:

1. **Office visits and procedure/surgery notes from the last 6 months of seeing patient.**
2. **Drug agreement now in effect**
3. **Medication records**
4. **MRI/CT/Lab reports**
5. **Other** ____

For the purpose of: Informing Dr. White of the patient's previous and/or current healthcare so that he may contribute to that care with Interventional Pain Management.

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.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the 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 an expiration date, event or condition, this authorization will expire in six months.

____ Date ________________________________
Signature of Patient or Legal Representative

____ ________________________________
Relationship to Patient (If Legal Representative) Witness if Legal Representative