

ADVANCED PAIN CENTERS, S.C.

Authorization for Use or Disclosure of Information

I, _____, hereby authorize **ADVANCED PAIN CENTERS, S.C.**, (“the Practice”) to use or disclose the following protected health information:

MEDICAL AND CLINICAL INFORMATION REGARDING A CLINICAL STUDY for hot flashes.

The protected health information may be disclosed to:

THE PUBLIC IN A SUMMARIZED FORMAT AS PART OF THE CLINICAL DOCUMENTATION FOR THE RESULTS OF THE STUDY. IN DETAIL TO THE SCIENTIFIC COMMUNITY TO VALIDATE THE SCIENTIFC/EDUCATIONAL STUDY.

This protected health information is being used or disclosed for the following purposes:

TO VALIDATE THE USE OF STELLATE GANGLION INJECTIONS TO REDUCE HOT FLASHES.

This authorization shall be in force and effect until the end of research study.

I understand that, as set forth in the practice’s Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

ATTN: Privacy Officer
ADVANCED PAIN CENTERS, S.C.
1800 Mc Donough Road, Suite 221
Hoffman Estates, Illinois

I understand that a revocation is not effective to the extent that the practice 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.

I understand that the treatment being provided for the practice is related to research and that my authorization of disclosures for research related purposes is a condition of this treatment. I understand that if I do not sign this authorization, then the Practice will not provide research related treatment to me.

I understand that I have the right to:

- Inspect or copy my 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.)
- Refuse to sign this authorization.

Signature of Patient

Date