WALNUT HILL
PAIN MANAGEMENT & WELLNESS

1 Grove Street – 2nd FL • New Britain, Connecticut 06053
(Phone) 860-506-5050 (FAX) 800-597-3430
www.CTPainRelief.com

NEW PATIENT INFORMATION PACKET & TREATMENT GUIDELINES

Thank you for your trust in Walnut Hill Pain Management & Wellness (WHPW). As an innovator in the practice of managing acute and chronic pain conditions, the office staff and your practitioner will work with you in achieving your goals. As such, we rely on you help and cooperation to be able to provide you with the best of care. ***READ THIS INFORMATION CAREFULLY***, answer all questions, and sign where indicated.

The expected benefits or goals for your treatment include improving your ability to engage in work, social, recreational and/or physical activities and ultimately improving your quality of life.

By completing all the information in this packet, you'll be taking the first step in ensuring the best possible outcomes. If at any time you have questions or need clarification, please ask. Return this completed packet to the front desk.

1. Please complete all information on this page and page 2
2. Be sure to indicate your preferred pharmacy on page 3
3. Sign and Date pages 6, 10, and 12
4. Sign and complete the information on page 11

CONFIDENTIAL PATIENT INFORMATION (PLEASE PRINT CLEARLY)

PERSONAL INFORMATION

Patient Name (First, Middle, Last):		Date of Birth:	Today's Date:
Street Address:		City, State, Zip Code:	
Sex at Birth: ❑Male ❑Female	Social Security Number:	Driver's License or Other ID Number:	State:
Home Phone Number:	Cell Phone Number:	E-mail Address:	
Marital Status: ❑Single ❑Married ❑Divorced/Sep. ❑Widowed ❑Other		If Married, Name of Spouse:	
Employer Name and Location:		Employer Phone Number:	
Emergency Contact Name and Relationship:		Emergency Contact Phone Number:	

Health Insurance

Name of Health Insurance Company:		Name of Insured:
Insurance Company Address (If Known):		City, State, Zip Code:
Group, Plan, or Patient ID Number (Please Present Insurance ID Card):		Insurance Company Phone Number:

Please List Any Medications You are Currently Taking:	Are you Capable of Making Your Own Medication Decisions?: ❑Yes ❑No

Have you Ever Been Arrested or Convicted of Any Drug Related Charge Including Narcotics?
*If "YES", Please Provide Charges and Date of Arrest:

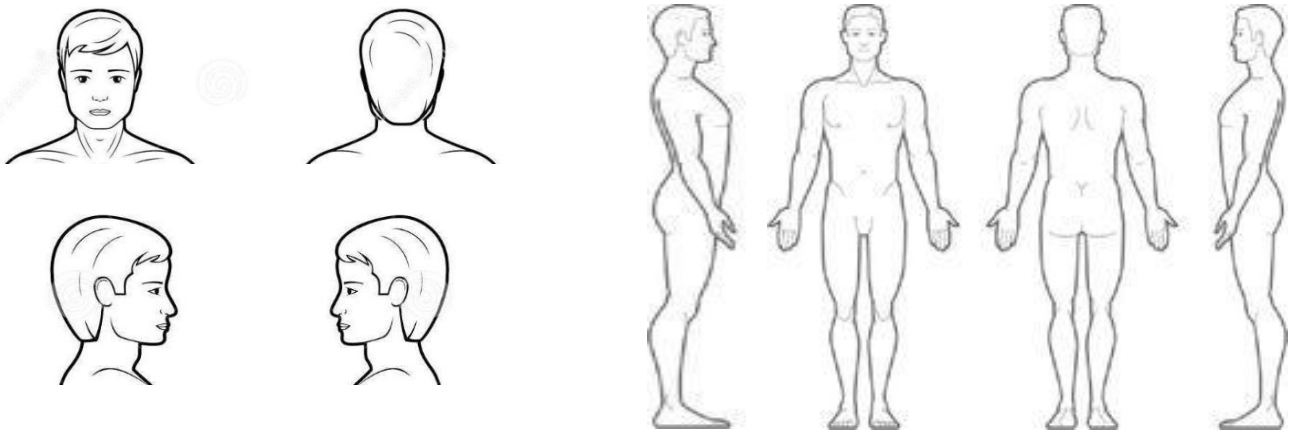
❑Yes* ❑No

Please List Any Recurring Medical Problems You Have (Diabetes, High Blood Pressure, Cancer, Etc.):

Please List Any Recurring Medical Problems Experienced by Your Immediate Family:

If Female, Are You Pregnant? ❑Yes ❑No ❑Maybe		If Yes, How Long? ❑0-3 Mos. ❑3-6 Mos. ❑6-9 Mos. ❑Unknown	
Do You Smoke? ❑Yes ❑No	If Yes, How Often?	Do You Drink Alcohol? ❑Yes ❑No	If Yes, How Often?
Do You Currently use Recreational Drugs? ❑Yes ❑No	If Yes, Which Ones, How Often?	Are you in recovery from any Substance Addiction? ❑Yes ❑No	If Yes, Which, and How Long?

On The Figures Below, Please Mark Your Areas of Pain and/or Discomfort:



Please Further Identify Your Major Problem Areas:

Complaint Area	Intensity of Pain (1-10)	Type of Pain (Circle All that Apply)	Frequency (Circle All that Apply)	Duration of Pain in Months or Years
Migraine	1 2 3 4 5 6 7 8 9 10	Dull Sharp Burning Stiff	Constant Frequent On/Off	_____Mos. _____Yrs.
Neck Pain	1 2 3 4 5 6 7 8 9 10	Dull Sharp Burning Stiff	Constant Frequent On/Off	_____Mos. _____Yrs.
Shoulder Pain	1 2 3 4 5 6 7 8 9 10	Dull Sharp Burning Stiff	Constant Frequent On/Off	_____Mos. _____Yrs.
Mid-Back Pain	1 2 3 4 5 6 7 8 9 10	Dull Sharp Burning Stiff	Constant Frequent On/Off	_____Mos. _____Yrs.
Low Back Pain	1 2 3 4 5 6 7 8 9 10	Dull Sharp Burning Stiff	Constant Frequent On/Off	_____Mos. _____Yrs.
Hip(s)	1 2 3 4 5 6 7 8 9 10	Dull Sharp Burning Stiff	Constant Frequent On/Off	_____Mos. _____Yrs.
Extremities (hands/feet)	1 2 3 4 5 6 7 8 9 10	Dull Sharp Burning Stiff	Constant Frequent On/Off	_____Mos. _____Yrs.
Other:	1 2 3 4 5 6 7 8 9 10	Dull Sharp Burning Stiff	Constant Frequent On/Off	_____Mos. _____Yrs.

INFORMED CONSENT AND AGREEMENT FOR TREATMENT

Please review carefully and sign this document. If you do not understand any of the information contained below or require additional clarification on the policies of this office regarding the prescribing of opioid medications, please ask. You will be required to sign this contract before receiving any opioid medications.

Pain relief is an important goal for your care. Opioid medications may be a helpful part of chronic pain treatment for some people. However, misuse of opioid medications may result in serious harm. As opioid use for pain management has increased in recent years, injury, addiction, and death due to misuse of opioids have also increased. Patients and health care providers both have responsibilities for the safe use of opioid medications when they are prescribed for pain.

This agreement provides important information on the potential benefits and risks of opioid medications and serves to document that both you and your provider agree on a care plan so that opioid medications are used in a way that is safe and effective in treating your pain. This agreement is reviewed and signed by all patients in our practice who receive opioids for chronic pain. It is important for you to understand that effective July 1, 2018, physicians treating patients for acute pain may not prescribe more than a 7-day supply of an opioid within a 7-day period.

Throughout your treatment plan, you have the right to:

- Have your pain prevented or controlled adequately.
- Have your pain and medication history taken.
- Have your pain questions answered.
- Know what medication, treatment or anesthesia will be given.
- Know the risks, benefits, and side effects of treatment.
- Know what alternative treatments may be available.
- Ask for changes in treatments if your pain persists.
- Receive compassionate and sympathetic care.
- Receive pain medication on a timely basis.
- Refuse treatment without prejudice from your physician.
- Include your family in decision-making.

Therefore, You have agreed to receive opioid (narcotic) medications for the treatment of chronic pain. These medications are being prescribed to decrease your pain and/or increase your ability to function. Opioid medications are just a part of the medical care which may be needed to accomplish this. Other treatments including non-opioid medications, exercise and physical therapy, psychological counseling or other therapies or treatments may also be prescribed.

→ My Preferred Pharmacy & Branch:_____

I will be provided with prescriptions only if I understand and agree to the following:

1. I understand that, depending on the drug and dose, I can become physically dependent on the medication and can develop withdrawal symptoms if the medication is stopped suddenly or the dose reduced rapidly. Although the risk is small there is a chance of developing an addiction to controlled substances if I am placed on them to control my pain.
2. Controlled substances can cause sedation, confusion, or other changes in mental state and thinking abilities. I understand that the decision to drive while I am taking controlled substances is my own

decision, and I agree not to be involved in any activity that may be dangerous to me or someone else, such as driving or operating any dangerous equipment, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself if I am in any way sedated, feel drowsy, or am not thinking clearly.

3. I will not use any illegal controlled substances including, but not limited to marijuana and cocaine.
4. I will not drive while intoxicated with alcohol.
5. I further understand that some of the other risks or side effects associated with Opioid Treatment may include:

    a. Physical side effects such as: mood changes, confusion, hallucinations, drowsiness, nausea, constipation, urination difficulties, an increased risk of falls, depressed breathing, itching, bone thinning and sexual difficulties, such as lowering of male hormone in men and cessation of menstrual periods in women.
    b. Physical dependence: Sudden stopping of an opioid may lead to withdrawal symptoms including abdominal cramping, pain, diarrhea, sweating, anxiety, irritability and aching.
    c. Tolerance: A dose of an opioid may become less effective overtime even though there is no change in your physical condition. If this happens repeatedly, your medication may need to be changed or discontinued.
    d. Addiction: A condition marked by a change in behavior leading to an inability to control the use of the prescribed opioid medication regardless of the harm it may cause you or others. It is more common in people with personal or family history of addiction but can occur in anyone.
    e. Hyperalgesia: Increased sensitivity to and/or increasing experience of pain caused by the use of opioids may require change or discontinuation of medication.
    f. Overdose: Taking more than the prescribed amount of medication or using with alcohol or other drugs can cause you to stop breathing resulting in coma, brain damage, or even death.
    g. Sleep apnea (periods of not breathing while asleep): May be caused or worsened by opioids.
    h. Risk to unborn child if patient is pregnant: If you take these meds during your pregnancy your baby may be born dependent on them and go through withdrawal right after birth. May also be associated with birth defects Tell your provider if you are or intend to become pregnant.
    i. Victimization: There is a risk that you or your household may be subject to theft, deceit, assault or abuse by persons seeking to obtain your medications for purposes of misuse.
    j. Life-threatening irregular heartbeat: Can occur with methadone, EKG may be needed.

6. Walnut Hill Pain & Wellness (“WHPW”) policy regarding the dispensing of controlled substances requires that I be seen regularly and I agree to make and keep my appointments. I will advise my physician/APRN of all other medicines and treatments that I am receiving.
7. If the medication requires adjustment, an appointment must be made to see the physician/APRN. No adjustments will be made over the telephone. My careful planning is required. I understand that medication refills and adjustments are done during office appointments except under very unusual

circumstances. I must stay with the prescribed dosing so that I do not run out of medication early. I understand that the WHPW policy is not to prescribe early. I agree that I will use my medication exactly as prescribed and that if I run out early, I may go without medication until the next prescription is due, possibly resulting in withdrawal symptoms.

8. I understand that the prescriptions are my responsibility once they are placed in my hand and that if anything happens to my prescription (lost, stolen, or accidentally destroyed), I may not receive a replacement from my physician. WHPW expects me to file a police report if my medication is stolen. I will be prepared to bring in a copy at my next office visit.
9. My physician/APRN will prescribe whatever medication he/she is comfortable with and thinks is best; he/she is not under any obligation to prescribe any specific medication.
10. I am aware of the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed included: injections, therapy, and surgery (if indicated).
11. I understand my physician/APRN may wean me off my medication, stop prescribing opioid medications or change the treatment should any one of the following occur plan if:
    a. I trade, sell or misuse the medication, for which I was prescribed.
    b. WHPW finds that I have broken any part of this agreement.
    c. I do not go for a blood, oral swab, or urine test when asked.
    d. My blood, oral swab or urine test shows the presence of medications the staff is not aware of
    e. The presence of illegal drugs or does not show medication(s) for which I am receiving a prescription.
    f. Any member of the professional staff of this clinic feels it is in my best interests that opioid medications are stopped.
    g. I display any aggressive or otherwise demeaning, disrespectful, or unprofessional behavior toward my physician/APRN or any of the office staff.
    h. I consistently miss appointments.
    i. It is the opinion of my physician that controlled substances are not very effective for my pain and/or my functional activity is not improved.
    j. I misuse the medication.
    k. I develop rapid tolerance or loss of effect from this treatment.
    l. I develop side effects that are significant and detrimental to me.
    m. I obtain controlled substances from other sources other than my physician/APRN without informing him or her.
    n. If Pill counts or test results indicate the improper use of the prescribed medication or the use of other drugs, and/or I fail to submit to such counts/tests on the day that I am called.
    o. I am arrested and/or convicted for a controlled or illicit drug violation, including drunk driving.
12. I agree to come to the WHPW with my medication on the same day that I am called and submit to a pill count, to determine proper usage of medication. The call to come to the WHPW can be made either randomly, or if a concern arises. I may also be required to bring my unused medication routinely

to each office visit. In addition, at any point during my care at WHPW, I agree to undergo a urine, oral swab, or blood screen to detect illegal substances or confirm proper use of prescribed medicine. This screening can be done randomly, without notice to me, the patient. If I do not have insurance or my insurance denies testing, I will be responsible for the cost of the test.

13. I give permission to the WHPW staff to call any pharmacy or another health care provider at any time, without my being informed, to discuss my past or present use of controlled or illegal substances.
14. I will not use my pain medication in higher than prescribed amounts for new problems that arise (toothache, surgery, etc.) unless authorized to do so. I will inform my other doctor(s) of my use of medication for chronic pain, and I will inform the WHPW staff if another physician prescribes controlled substances for the acute problem. My physician/APRN at WHPW is my primary practitioner with regard to my pain medications and will alert WHPW staff if I am prescribed pain medication by any other doctor.
15. (Females only) Due to the risks of certain medications to unborn children, I will inform all physicians, obstetrician/gynecologist and WHPW, immediately if I become pregnant or decide to try to become pregnant. I am aware that should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opioids. I am aware the use of opioids is not generally associated with risk of birth defects, but birth defects can occur whether or not the mother is on medicines. There is always the possibility that my child will have a birth defect while I am taking an opioid.
16. (Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my physician/APRN may check my blood to see if my testosterone level is normal.
17. Abstinence Syndrome (Withdrawal Syndrome): Stopping my opioid, antiseizure or antidepressant medication abruptly may result in withdrawal symptoms (flu-like symptoms, GI distress, diarrhea, sweating, heart palpitations, and rarely seizures or death). I should wean from my medications rather than stopping them abruptly.

I have read the above Agreement and understand the Agreement, have had all my questions concerning this Agreement answered to my satisfaction, and I agree to abide by the terms of this Agreement if I am placed on controlled substances (including, but not limited to narcotic analgesics). I have received a copy of the Agreement. By signing this form voluntarily, I give my consent for the treatment of my pain with narcotic/opioid pain medicines.

Patient's Signature_____ Date:_____

Witness Name:_____ Signature:_____

PAYMENT & APPOINTMENT POLICY

To help provide the most efficient and reasonably priced health care services, it is necessary for us to have a financial policy stating our requirements for payment of services provided to our patients. Patients are responsible for the payment of all services provided by WHPW.

We will assist you in any way we can to facilitate the settling of your account. It is essential for you to provide us with accurate and up-to-date insurance information at **each visit**. It is your responsibility to notify us of any changes in insurance so that claims can be filed correctly. Any error, causing a delay in processing and payment, puts the burden of the bill on you. Although highly unlikely, an approval from your insurance company does not guarantee payment. The patient is ultimately responsible for payment of the services rendered.

Health Insurance

It is our policy to file insurance as a courtesy to you if we have accurate and complete insurance information. The balance due is still your responsibility if we have not received payment from the insurance company within the contractual time frame.

We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned physician participates in your plan. Out of network charges may have higher deductibles and copayments.

Financial responsibility

Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier. WHPW accepts bank checks and cash for payments. An administrative re-billing charge of 10% of the balance owed will be assessed to each account over 30-days past due. 90-day past-due balances are subject to third party collection and/or litigation.

Co-Payments

Copayments for visits are due at the time of service. If you are unable to make your copayment at the time of service, WHPW reserves the right to reschedule your appointment until a time that you are able to make your copayment. Payment for any outstanding balance is due at your appointment.

Balances and payment plans

For patients who need financial arrangements, we will offer counseling and options that would fit their needs and capabilities. Balances need to be resolved before the next visit, unless a payment plan has been arranged. Payment plans need to be in good standing before each visit.

Self-pay

If you do not have health insurance, or if your health insurance will not pay for services rendered by our practice, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available from our front desk). Self-pay patients are expected to make payment in full at the time of service.

Workers' Compensation

For Worker's Compensation claims, it is our policy to bill your employer or the Worker's Compensation carrier for services rendered. If you are covered, we will accept the payment made by Worker's Compensation as payment in full. If Worker's Compensation denies payment or goes into litigation, the entire balance will become your responsibility and will be due within 10 days from the date of the denial. It is your responsibility to contact us with the name and address of your employer or the insurance company at the time the appointment is made and to provide the office with a copy of your Notice of Compensation Payable Letter from Worker's Compensation. All insurance is verified prior to the patient's initial visit.

Appointments
Once accepted as a WHPW patient, all your visits will require an appointment. While “emergency” appointments may be granted if time allows, WHPW does not offer walk-in service. All follow-up appointments will be clearly communicated and you will be reminded. However, you can always call the office if there are any questions regarding your treatment plan.

Late arrivals
We understand that there are times when you are late for an appointment due to emergencies or obligations for work or family. If you are running late, please call the office. In this case, we will make every effort to see you but you may have to be re-scheduled for another day.

Cancellations
Life is complicated and busy. We understand the best plans may not be possible. Therefore, we urge you to notify us more than 24 hours in advance if your schedule will not permit you to keep your appointment. We will gladly reschedule you in the earliest available slot that would fit your schedule. Be advised that, due to the nature of our practice, we can only prescribe opioid medications after a meaningful patient contact, which includes a visual, physical and verbal assessment only possible during a clinic or procedure visit. This means that occasionally, there may be a brief gap in the continuity of care.

Late cancellations and no-shows
We take all our patient encounters seriously and strive to offer each patient the best quality care they deserve. A “no-show” or a cancellation without 24-hour notice as a new patient may result in reduced access and the inability to reschedule an appointment. Therefore, in these cases, you may be responsible for an administrative cancellation fee of $75.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of WHPW, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of WHPW. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical staff, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical personnel that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as Required By Law, Public Health issues as required by law: Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

Patient's Signature:_____ Date:_____

Witness Name:_____ Signature:_____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHROIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing, we *may not be allowed* to process your insurance claims.

Today's Date:_____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare organization. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ASLO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.**

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or consents:_____

1. How would you like to be addressed when summoned from the reception area?
   ❑First Name Only ❑Proper Sir Name ❑Other:_____
   Preferred Pronouns:_____

2. Please list any parties who can have access to your health information. This includes stepparents, grandparents, and any care takers who can have access to this patient's records:

   Name:_____ Relationship:_____

   Name:_____ Relationship:_____

3. I authorize contact from this office to **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA**:
   ❑Cell Phone ❑Work Phone ❑Text (SMS) Message to my Cell Phone
   ❑Home Phone ❑E-mail ❑**Any of These**

4. I authorize **INFORMATION ABOUT MY HEALTHCARE** to be conveyed via:
   ❑Cell Phone ❑Work Phone ❑Text (SMS) Message to my Cell Phone
   ❑Home Phone ❑E-mail ❑**Any of These**

5. I approve being contacted about **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS, or NEW HEALTH INFORMATION** on behalf of this healthcare facility via:
   ❑Cell Phone ❑Work Phone ❑Text (SMS) Message to my Cell Phone
   ❑Home Phone ❑E-mail ❑**Any of These**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize that this office may recommend products and/or services to promote your improved health. This office may or m ay not receive third party remuneration from these affiliated companies. We, under the current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

For Office Use Only:

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this acknowledgement but was unsuccessful because:

❑Treatment was an Emergency ❑I couldn't communicate with the Patient ❑The Patient refused to sign
❑Patient was unable to sign ❑Other:_____

_____

Signature of Privacy Officer

WALNUT HILL
PAIN MANAGEMENT & WELLNESS

1 Grove Street – 2nd FL • New Britain, Connecticut 06053
(Phone) 860-506-5050 (FAX) 800-xxx-xxxx

MEDICAL RECORDS REQUEST/RELEASE AUTHORIZATION

By signing this form below, I authorize Walnut Hill Paing & Wellness (WHPW) to use, receive, release or disclose the below indicated protected health information. The patient or their representative may revoke this authorization by notifying WHPW in writing. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to re-disclosure by the recipient. This Records Request/Release Form shall expire exactly one year from the signature date indicated below.

Person or Organization from whom records are being requested or to whom records should be released:

_____

Purpose for use, release or disclosure of protected health information:

_____

Protected Health Information to be sent to ***WHPW, 1 Grove St., 2nd FL - New Britain, CT 06053***

- ❑ Copies of all medical records for the period of _____ to _____
- ❑ Copies of the information described below for the period of _____ to _____
- ❑ Examination Reports
- ❑ Lab, X-Ray, ED, Etc. Reports
- ❑ Reports and records from other physicians
- ❑ Other: _____

I understand that the following protected health information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV); behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions of a sensitive nature.

I authorize this information to be transmitted by way of ground parcel, fax, certified mail, electronic or direct delivery to, or pick up from ***Walnut Hill Pain Management & Wellness.***

I am fully aware of my right under HIPAA regulations and have signed a copy of WHPW's Notice of Privacy Practices. I have discussed any concerns I have with the release, use or disclosure of my protected health information with WHPW's Privacy Compliance Officer and/or other appropriate office personnel.

I understand that WHPW assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release WHPW form all legal liability that may arise from the authorization.

Patient's Name:_____ Signature:_____ Date:_____

Patient's Date of Birth:_____ Social Security Number:_____

If Minor, Parent/Guardian Signature:_____ Date:_____