Nocio
Interventional Pain Management

Tel: (480) 818-4314
Fax: (602) 865-8171

Consent To Disclose Confidential Protected Health Information

Nocio, LLC participates in an electronic health information exchange with other health care providers. We and the other participating health care providers are referred to as "*Participants*." With your permission, our participation in this health information exchange does two things:

1. It provides the electronic method for us to disclose our confidential health information about you to other *Participants* who are treating you and request your information; and
2. It allows other *Participants* to electronically disclose their confidential health information about you to us if we request your information for our treatment of you.

The purpose of this consent is to obtain your permission for the sharing of information from your health record between *Participants* belonging to the electronic health information exchange who are involved with your treatment.

I, _____, authorize
Nocio Interventional Pain Management
4400 N Scottsdale Rd, Suite 805
Scottsdale, AZ 85251
Fax: 602-865-8171
Phone: 480-818-4314

☐ to receive data only
☐ to send and receive data
☐ to opt out

with care providers who are directly involved in your care.

Rights:

- I may refuse to authorize sharing of my information through the electronic health information exchange by selecting "*to opt out.*" I understand that selecting this option will not prevent me from receiving care from Nocio, LLC.

- This authorization may be revoked at any time by providing written notice of revocation. I understand that I cannot revoke this authorization retroactively for information already released.

I acknowledge I have had the opportunity to ask questions and that my selection above accurately reflects my wishes.

_____ _____
Signature of Patient or Legal Representative Date

_____
Print Name