

## DNA Health Systems Advanced Pain Treatment Center REGISTRATION FORM

|  |                                  |   |                                       |   |   |   |   |
|--|----------------------------------|---|---------------------------------------|---|---|---|---|
| Today's date:  |                                  |   |                                       | PCP:  |   |   |   |
| <b>PATIENT INFORMATION</b>   |                                  |   |                                       |   |   |   |   |
| Patient's last name:   |                                  | First:                                      | Middle:                               | <input type="checkbox"/> Mr.<br><input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss<br><input type="checkbox"/> Ms. | Marital status (circle one)<br>Single / Mar / Div / Sep / Wid |   |
| Is this your legal name?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | If not, what is your legal name? |   | (Former name):                        |   | Birth date:<br>/ /  | Age:  | Sex:<br><input type="checkbox"/> M <input type="checkbox"/> F |
| Street address:  |                                  |   | Social Security no.:                  |   | Home phone no.:<br>(    )                                     |   |   |
| P.O. Box:  |                                  | City:                                       |                                       | State:  |   | ZIP Code:   |   |
| Occupation:  |                                  | Employer:                                   |                                       |   | Employer phone no.:<br>(    )                                 |   |   |
| Chose clinic because/Referred to clinic by (please check one box):                   |                                  |   |                                       | <input type="checkbox"/> Dr.                                  |   | <input type="checkbox"/> Insurance Plan                       | <input type="checkbox"/> Hospital                             |
| <input type="checkbox"/> Family  | <input type="checkbox"/> Friend  | <input type="checkbox"/> Close to home/work | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Other                                |   |   |   |
| Other family members seen here:  |                                  |   |                                       |   |   |   |   |

### INSURANCE INFORMATION-PLEASE PRESENT YOUR INSURANCE CARD

|  |                          |                               |  |                                |                                |                   |
|--|--------------------------|-------------------------------|--|--------------------------------|--------------------------------|-------------------|
| Person responsible for bill:   |                          | Birth date:<br>/ /            | Address (if different):                                  |                                | Home phone no.:<br>(    )      |                   |
| Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No        |                          |                               |  |                                |                                |                   |
| Occupation:  | Employer:                | Employer address:             |  |                                | Employer phone no.:<br>(    )  |                   |
| Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No |                          |                               |  |                                |                                |                   |
| Please indicate primary insurance  |                          |                               |  |                                |                                |                   |
| <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/>      | <input type="checkbox"/> Welfare (Please provide coupon) |                                | <input type="checkbox"/> Other |                   |
| Subscriber's name:   |                          | Subscriber's S.S. no.:        | Birth date:<br>/ /                                       | Group no.:                     | Policy no.:                    | Co-payment:<br>\$ |
| Patient's relationship to subscriber:  |                          | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse                          | <input type="checkbox"/> Child | <input type="checkbox"/> Other |                   |
| Name of secondary insurance (if applicable):   |                          | Subscriber's name:            |  | Group no.:                     | Policy no.:                    |                   |
| Patient's relationship to subscriber:  |                          | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse                          | <input type="checkbox"/> Child | <input type="checkbox"/> Other |                   |

### ACCIDENT INFORMATION-COMplete ONLY IF VISIT IS DUE TO AN ACCIDENT

|                                   |                      |                  |           |  |
|-----------------------------------|----------------------|------------------|-----------|--|
| Workers Comp/Auto Insurance _____ |                      | Date of Accident | Claim No. | Type of Accident:  |
| Address _____                     |                      |                  |           | <input type="checkbox"/> Auto <input type="checkbox"/> Other |
| City _____                        | State ____ Zip _____ | Phone _____      |           | <input type="checkbox"/> Work Related                        |

### IN CASE OF EMERGENCY

|  |  |                          |                           |                           |
|--|--|--------------------------|---------------------------|---------------------------|
| Name of local friend or relative (not living at same address): |  | Relationship to patient: | Home phone no.:<br>(    ) | Work phone no.:<br>(    ) |
|--|--|--------------------------|---------------------------|---------------------------|

The above information is true to the best of my knowledge. I request that payment of authorized Medicare/other insurance benefits be made on my behalf to DNA Health Systems Advanced Pain Treatment Center for any services furnished me by physician or supplier. I authorize the release of my medical information to the Centers for Medicare & Medicaid Services and/or my insurance company and its agents; any information needed to determine these benefit/benefits payable for related services. I am responsible for all charges, regardless of insurance status, as well as copayments and deductibles.

\_\_\_\_\_  
Patient/Guardian signature

\_\_\_\_\_  
Date



**INITIAL PAIN ASSESSMENT**

DNA Health Systems Advanced Pain Treatment  
1907 Lebanon Church Rd # 240  
West Mifflin, PA 15122-2452  
(412) 561-PAIN(7246)

Please complete the following questionnaire to help us understand your pain problem and design the best treatment plan for you. Our records are strictly confidential and no one is permitted to review these records without your written permission

Name \_\_\_\_\_

What is the main complaint for which you are seeking treatment? \_\_\_\_\_

How long have you been experiencing this pain? \_\_\_\_\_

How do you believe your pain started ? \_\_\_\_\_

**A. Please circle each word that best describes your average pain over the last month**

- |           |          |          |          |           |
|-----------|----------|----------|----------|-----------|
| Piercing  | Stabbing | Shooting | Burning  | Grinding  |
| Throbbing | Cramping | Aching   | Stinging | Squeezing |
| Numbing   | Itching  | Tingling | Crushing | Boring    |

**B. Please indicate you level of pain on a scale of 0-10, with 0 being no pain and 10 being the worst pain imaginable**

Your average pain \_\_\_\_\_ Your worst pain \_\_\_\_\_ Your least pain \_\_\_\_\_

**C. In response to the following activities, please indicate your level of pain on a scale of 0-10. Remember, 0 is no pain and 10 is the worst pain imaginable.**

- |                         |                          |
|-------------------------|--------------------------|
| Lying down _____        | Sleeping _____           |
| Standing _____          | Cough/Sneeze _____       |
| Sitting _____           | Urination _____          |
| Walking _____           | Bowel movements _____    |
| Walking up stairs _____ | Lifting/Bending _____    |
| Medication _____        | Changing Positions _____ |

**D. Please circle the response that best fits. If there is a blank, fill in the blank**

When is your pain usually the worst? Morning Afternoon Evening No Pattern  
 Is your pain? Constant Nearly Constant Intermittent Occasional  
 How many hours do you sleep? \_\_\_\_\_  
 Does your pain awaken you from sleep? YES NO  
 Describe your emotional state (circle all that apply)  
 Agitated Anxious Withdrawn Sad Fearful Angry No Problems Other \_\_\_\_\_

Have you or are you currently seeing a psychiatrist/psychologist to help you deal with your pain or depression? YES NO

If yes, please indicate the name and address below

Name \_\_\_\_\_

Address \_\_\_\_\_

Would you like us to send progress reports to this person? YES NO

**E. Please circle the response that best fits. If there is a blank, fill in the blank**

Do you drink alcoholic beverages ? Never Rarely Occasionally Regularly Daily

Do you drink alcohol to reduce your pain? YES NO

Do you or have you used tobacco? (Cigarettes, snuff, pipe, cigar) YES NO

If yes, please tell us how much and for how long \_\_\_\_\_

If you quit using tobacco, please indicate when you quit \_\_\_\_\_

Do you use any of the following drugs? Circle all that apply.

- |           |           |             |                   |
|-----------|-----------|-------------|-------------------|
| Marijuana | Heroin    | Cocaine     | Amphetamines      |
| Inhalants | Sedatives | Other _____ | None of the above |

**F. Please complete the following:**

Current occupation or last job? \_\_\_\_\_

Your present employment status

- |            |               |            |                  |
|------------|---------------|------------|------------------|
| Full time  | Part time     | Light Duty | Leave of absence |
| Unemployed | Retired       | Disabled   | Student          |
| Homemaker  | Worker's comp |            |                  |

Has your pain forced you to chain: Change jobs      Limit your work      Stop working

Have you tried to return to work?      YES      NO

If yes, how long were you able to return? \_\_\_\_\_

Would you return to work if you had less pain?      YES      NO

**G. Please circle any claims you have filed or that are settled with regard to your pain:**

- |                        |                         |                            |
|------------------------|-------------------------|----------------------------|
| Worker's compensation  | Personal Injury lawsuit | Social Security disability |
| Motor vehicle accident | Other _____             | None                       |

**H. For the next series of questions, if given a choice, circle the response that best fits. If there is a blank, fill in your response.**

Are you currently:      Single      Married      Divorced      Widowed      Separated

Are you pregnant or planning on becoming pregnant?      YES      NO

**I. Please tell us about your previous evaluations and treatments for you pain.**

Please list any of the following test you have had in the last two years.

| Test             | Date | Facility where test was done | Ordering Physician |
|------------------|------|------------------------------|--------------------|
| X-ray            |      |                              |                    |
| CT Scan          |      |                              |                    |
| MRI              |      |                              |                    |
| EMG              |      |                              |                    |
| Nerve Conduction |      |                              |                    |
| Myelogram        |      |                              |                    |
| Bone Scan        |      |                              |                    |
| Other            |      |                              |                    |

**I. Please list all physicians, practitioners or therapist you have seen regarding you pain and indicate what treatment(s) were performed and how your response.**

| Date | Physician, practitioner or therapist | Treatment | % Improvement |
|------|--------------------------------------|-----------|---------------|
|      |                                      |           |               |
|      |                                      |           |               |
|      |                                      |           |               |

**J. Please list all medications you have taken for your pain?**

| Medication | % Improvement | Reason for Stopping Medication |
|------------|---------------|--------------------------------|
|            |               |                                |
|            |               |                                |
|            |               |                                |
|            |               |                                |



|  |  |  |
|--|--|--|
|  |  |  |
|  |  |  |
|  |  |  |

Do you experience any of the following?  
 Review of Symptoms (please indicate all that apply):

|   | Yes                      | No                       |                      | Yes                      | No                       |
|---|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|
| Fever                                   | <input type="checkbox"/> | <input type="checkbox"/> | Weight Loss          | <input type="checkbox"/> | <input type="checkbox"/> |
| Night Sweats                            | <input type="checkbox"/> | <input type="checkbox"/> | Swelling             | <input type="checkbox"/> | <input type="checkbox"/> |
| Rash                                    | <input type="checkbox"/> | <input type="checkbox"/> | Cough                | <input type="checkbox"/> | <input type="checkbox"/> |
| Sputum Production                       | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath  | <input type="checkbox"/> | <input type="checkbox"/> |
| Wheezing                                | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pain           | <input type="checkbox"/> | <input type="checkbox"/> |
| Palpitations                            | <input type="checkbox"/> | <input type="checkbox"/> | Any Bleeding         | <input type="checkbox"/> | <input type="checkbox"/> |
| Abdominal Pain                          | <input type="checkbox"/> | <input type="checkbox"/> | Constipation         | <input type="checkbox"/> | <input type="checkbox"/> |
| Diarrhea                                | <input type="checkbox"/> | <input type="checkbox"/> | Black bowel movement | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood in stool                          | <input type="checkbox"/> | <input type="checkbox"/> | Nausea               | <input type="checkbox"/> | <input type="checkbox"/> |
| Headache                                | <input type="checkbox"/> | <input type="checkbox"/> | Lightheadness        | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness                               | <input type="checkbox"/> | <input type="checkbox"/> | Vision Changes       | <input type="checkbox"/> | <input type="checkbox"/> |
| Easy Bruising                           | <input type="checkbox"/> | <input type="checkbox"/> | Urinary Frequency    | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty Urinating                    | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy            | <input type="checkbox"/> | <input type="checkbox"/> |
| Bowel or Bladder Incontinence           |                          |                          |                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Weakness/Paralysis of the arms and legs |                          |                          |                      | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Signature \_\_\_\_\_

Date: \_\_\_\_\_

Reviewed By: \_\_\_\_\_

Date: \_\_\_\_\_

**DNA Advanced Pain Treatment Center  
Notice and Acknowledgement**

**Acknowledgement:**

I acknowledge that I have received the attached copy of the DNA Advanced Pain Treatment Center (“DNA”) Notice of Privacy Practices.

\_\_\_\_\_  
Patient or Personal Representative  
Signature

\_\_\_\_\_  
Date

If Personal Representative’s signature appears above, please describe Personal Representative’s relationship to the patient:

\_\_\_\_\_

**DNA Advanced Pain Treatment Center (“DNA”)  
NOTICE OF PRIVACY PRACTICES**

**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 is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). Your "protected health information" means any of your written and oral health information, including demographic data that can be used to identify you and relates to your past, present or future physical or mental health condition.

**I. Uses and Disclosures of Protected Health Information**

DNA may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless DNA has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA Privacy Regulations or State law. Disclosures of your protected health information for the purposes described in this Notice may be made in writing, orally, or by facsimile.

**A. 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 treatment purposes. For example, we may disclose your protected health information to a consulting physician to coordinate your treatment.

**B. Payment.** Your protected health information will be used, as needed, to obtain payment for the services that we provide. For example, we may communicate with your health insurer or Medicare to get coverage approval for your care or to submit our bill for payment. We may also submit your information to another of your providers for their payment activities.

**C. Operations.** We may use or disclose your protected health information, as necessary, for our own health care operations in order to facilitate the function of DNA and to provide quality care to all patients. Some examples of health care operations include such activities as quality assessment and improvement activities; accreditation, certification, licensing or credentialing activities; review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs; business management and general administrative activities. We may also disclose patient information to another provider or health plan for their health care operations, but only if they have a patient relationship with you.

**D. Other Uses and Disclosures.** As part of treatment, payment and healthcare operations, we may also use or disclose your protected health information for the following purposes: to remind you of an appointment; To inform you of potential treatment alternatives or options; To inform you of health-related benefits or services that may be of interest to you.

**II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object**

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

**A. When Legally Required.** We will disclose your protected health information when we are required to do so by any Federal, State or local law.

**B. When There Are Risks to Public Health.** We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.

- To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

**C. To Report Abuse, Neglect Or Domestic Violence.** We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

**D. To Conduct Health Oversight Activities.** We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law.

**E. In Connection With Judicial And Administrative Proceedings.** We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order.

**F. For Law Enforcement Purposes.** We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries.
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if DNA has a suspicion that your death was the result of criminal conduct.
- In an emergency in order to report a crime.

**G. To Coroners, Funeral Directors, and for Organ Donation.** We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**H. For Research Purposes.** We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board or privacy board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

**I. In the Event of A Serious Threat To Health Or Safety.** We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

**J. For Specified Government Functions.** In certain circumstances, the Federal regulations authorize DNA to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

**K. For Worker's Compensation.** DNA may release your health information to comply with worker's compensation laws or similar programs.

### **III. Uses and Disclosures Permitted Without Authorization But With Opportunity to Object**

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your care or payment related to your care. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

### **IV. Uses and Disclosures Which You Authorize**

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

## V. Your Rights

You have the following rights regarding your health information:

**A. The right to inspect and copy your protected health information.** You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A “designated record set” contains medical and billing records and any other records that your practitioner and DNA uses for making decisions about you.

Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last pages of this Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

**B. The right to request a restriction on uses and disclosures of your protected health information.** You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information 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.

DNA is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If DNA does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

**C. The right to request to receive confidential communications from us by alternative means or at an alternative location.** You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

**D. The right to have DNA amend your protected health information.** You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

**E. The right to receive an accounting.** You have the right to request an accounting of certain disclosures of your protected health information made by DNA. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a DNA directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

**F. The right to obtain a paper copy of this notice.** Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

**VI. Our Duties**

DNA is required by law to maintain the privacy of your health information and to provide you with this Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that we maintain.

**VII. Complaints**

You have the right to express complaints to DNA and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to DNA by contacting DNA's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

**VIII. Contact Person**

DNA's contact person for all issues regarding patient privacy and your rights under the Federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. Complaints against DNA, can be mailed to the Privacy Officer by sending it to:

DNA Advanced Pain Treatment Center  
ATTN: Privacy Officer  
P.O. Box 747  
Greensburg, PA 15601

The Privacy Officer can be contacted by telephone at \_\_\_\_\_

**IX. Effective Date**

This Notice is effective April 14, 2003.

**AUTHORIZATION FOR USE OR DISCLOSURE OF  
INFORMATION**

I, \_\_\_\_\_ (BIRTH DATE) \_\_\_\_\_,  
(SSN/MR#) \_\_\_\_\_ HEREBY AUTHORIZE:  
\_\_\_\_\_ TO DISCLOSE THE  
FOLLOWING PROTECTED HEALTH INFORMATION:

\_\_\_\_\_  
\_\_\_\_\_

THE PROTECTED HEALTH INFORMATION MAY BE DISCLOSED TO:  
DNA ADVANCED PAIN TREATMENT CENTER  
275 CURRY HOLLOW ROAD  
SUITE #290  
PITTSBURGH, PA 15236  
412-561-7246 PHONES  
412-235-4012 FAX

THIS PROTECTED HEALTH INFORMATION IS BEING USED OR DISCLOSED  
FOR THE FOLLOWING PURPOSES:

\_\_\_\_\_

\_\_\_\_\_ THIS AUTHORIZATION WILL EXPIRE ON:  
\_\_\_\_\_

**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). I FURTHER  
UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS  
AUTHORIZATION.**

\_\_\_\_\_  
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

\_\_\_\_\_  
NAME OF PATIENT OR PERSONAL REPRESENTATIVE

\_\_\_\_\_  
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

\_\_\_\_\_  
DATE