NEUROSPINE CENTERS

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HIPAA - Use & Disclosure of Protected Health Information

Patient Authorization & Acknowledgement of Receipt

Authorization for the disclosure of Protected Health Information (PHI) for Treatment, Payment, or Healthcare Operations (164.508 (a)).

I, the undersigned, understand that as part of my health care, **NeuroSpine Centers** originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for the future care of treatment. I understand that this information serves as

- A basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my health care,
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were provided;
- A tool for routine healthcare operations such as assessing the quality and reviewing the competence of health care professionals.

I have been provided with a copy of the Notice of Privacy Practices that provides a complete description of information uses and disclosures.

Patient Consent for Use & Disclosure of PHI

Consent to the use and disclosure of Protected Health Information (PHI) for Treatment, Payment, or Healthcare Operations (TPO) (164.506 (a))

I understand that:

- I have the right to review the provider's Notice of Privacy Practices before signing this consent;
- The provider reserves the right to revise its Notice of Privacy Practices at any time and that before implementation will mail a copy of any revised notice to the address I have provided if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or health care operations and that the provider has already taken action in reliance thereon.

By signing below, I consent to use and disclose my protected health information (PHI) to carry out treatment, payment, and health care operations (TPO).

We may also use any of the following methods to send you appointment reminders, patient statements, surveys, occasional news, educational messages, and information related to insurance issues or your clinical care, including laboratory test results, etc.:

- ❑ Mail - to home or other alternate location
- ❑ Telephone - cell phone, home or alternate number. (We may also leave a message on your voicemail)
- ❑ Text Messages (standard text messaging rates may apply)
- ❑ Emails

Signature: _____ **Date:** _____
Print Name: _____ **Telephone:** _____

Complete below if not signed by the patient (please indicate relationship)

Name: _____ Relationship: _____
Address: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other (please specify): _____