Laser Spine and Institute PLLC

PRIVACY PRACTICES ACKNOWLEDGEMENT AND PATIENT CONSENT TO THE USE & DISCLOSURE OF HEALTH INFORMATION

FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I, _____, understand that as part of my health care, paper and/or electronic records are originated and maintained describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or 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 contribute to my care
- A source of information for applying my diagnosis/diagnoses 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 quality

I have been presented with, read and understand a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations
- The right to request a copy of this document

I understand that it is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I wish to have the following restrictions to the use or disclosure of my health information: _____

_____

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I also understand that in order to file insurance benefits on my behalf, it will be necessary to release information regarding the medical treatment that I have received.

I fully understand and **I ACCEPT** or **I DECLINE** the terms of this consent. (**must circle one**)

I CONSENT **I REFUSE** to be treated. (**must circle one**)

Patient's Signature:_____Date:_____

Printed Name:_____

If not signed by the patient, please indicate your relationship to the patient.

Signature:_____ Relationship:_____

Printed Name:_____