INTERVENTION SPINE & PAIN

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PATIENT CONSENT AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I understand that as part of the provision of healthcare services, Interventional Spine & Pain creates and maintains health records and other information describing among other things, my health history, symptoms, examinations, test results, diagnoses, treatments, and any plans for future care of treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review, prior to signing this consent. I understand that the organization reserves the right to change their privacy practices and the terms of this notice at any time. Upon you request, we will provide you with any revised Notice of Privacy Practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment, and healthcare operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purpose of treatment, payment or healthcare operations restricted. I also understand that the practice and I must agree to any restrictions in writing and I request on the use and disclosure of my Protected Health Information which has been previously agreed upon.

PATIENT OF PERSONAL REPRESENTATIVE (PRINT)	DATE
PATIENT OR PERSONAL REPRESENTATIVE (SIGN)	SOCIAL SECURITY (IDENTIFICATION PURPOSE ONLY)
WITNESS SIGNATURE	DATE