SISKIN SPINE & REHABILITATION SPECIALIST

Patient Consent for Use or Disclosure Of Protected Health Information
For Treatment, Payment or Healthcare Operations

I hereby consent to the use or disclosure of his/her individually identifiable health information ("protected health information") by SISKIN SPINE & REHAB SPECIALIST ("Facility") in order to carry out treatment, payment, or health care operations. I have the right to review the Facility's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and also have the right to review such Notice prior to signing this consent form.

Facility reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the Facility does change the terms of its Notice of Privacy Practices, I may obtain a copy of the revised Notice by written request to the practice. I retain the right to request that the Facility further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Facility is not required to agree to such requested restrictions; however, if the Facility does agree to my requested restriction(s), such restrictions are then binding on the Facility.

At all times, I retain the right to revoke this Consent. Such revocation must be submitted to the Facility in writing. The revocation shall be effective except to the extent that the Facility has already taken action in reliance on the consent. The Facility may refuse to treat me if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the Facility is required by law to treat individuals). If I (or authorized representative) sign this Consent form and then revokes Consent, the Facility has the right to refuse to provide further treatment to patient as of the time of revocation (except to the extent that Facility is required by law to treat individuals).
I HAVE READ AND UNDERSTAND THIS INFORMAITON. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____ _____
Signature of Patient or legal Guardian Date

_____ _____
Patient Name Print Name of Patient or Legal Guardian*

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient:_____

If we are unable to reach you, are there any relatives or friends with whom you authorize our office to discuss your health information? _____YES _____NO
_____Relationship:_____ Phone:_____
_____Relationship:_____ Phone:_____
_____Relationship: _____Phone:_____

By my signature, I authorize you to discuss my health information with those individuals indicated above. This authorization will be in effect until revoked in writing.

_____ _____
Patient/Guarantor Signature Date