# Consent Form/Description

# HIPAA Consent Form

**Preliminary Draft Subject to Change**

[This form does not constitute legal advice and is for educational purposes only. This form is based on current federal law and subject to change based on changes in federal law or subsequent interpretative guidance. This form is based on federal law and must be modified to reflect state law where that state law is more stringent than the federal law or other state law exceptions apply.]

## Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by The Spine & Neuromuscular Associates of SEI, PSC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of The Spine & Neuromuscular Associates of SEI, PSC. I understand that diagnosis or treatment of me by The Doctors of The Spine & Neuromuscular Associates of SEI, PSC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Spine & Neuromuscular Associates of SEI, PSC is not required to agree to the restrictions that I may request. However, if The Spine & Neuromuscular Associates of SEI, PSC agrees to a restriction that I request, the restriction is binding on The Spine & Neuromuscular Associates of SEI, PSC and The Doctors of The Spine & Neuromuscular Associates of SEI, PSC

I have the right to revoke this consent, in writing, at any time, except to the extent that the Doctors of the The Spine & Neuromuscular Associates of SEI, PSC or The Spine & Neuromuscular Associates of SEI, PSC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review The Spine & Neuromuscular Associates of SEI, PSC 's Notice of Privacy Practices prior to signing this document. The Spine & Neuromuscular Associates of SEI, PSC 's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the The Spine & Neuromuscular Associates of SEI, PSC. The Notice of Privacy Practices for The Spine & Neuromuscular Associates of SEI, PSC is also provided at 120 Industrial Dr, Lawrenceburg, IN 47025. This Notice of Privacy Practices also describes my rights and the The Spine & Neuromuscular Associates of SEI, PSC 's duties with respect to my protected health information.

The Spine & Neuromuscular Associates of SEI, PSC reserves the right to change the privacy practices that

are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing The Spine & Neuromuscular Associates of SEI, PSC, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Description of Personal Representative Authority

_____
Date

## Patient Acknowledgment of Privacy Notice

### To Be Maintained with Patient's Chart

This is to acknowledge that I (print name) _____ have been given the opportunity to review The Spine & Neuromuscular Associates of SEI, PSC, **Notice of Privacy Practices.**

I understand that I have the right to request a personal copy of this office's **Notice of Privacy Practices**.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority