Advanced Spine Associates, P.A.

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Surgeons Specializing in Spinal Disorders

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Advanced Spine Associates, P.A. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Advanced Spine Associates, P.A. Notice of Privacy Practice provides a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Advanced Spine Associates, P.A. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Advanced Spine Associates, P.A at 8232 Highway 65 NE, Spring Lake Park, MN 55432.

With this consent, Advanced Spine Associates, P.A. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Advanced Spine Associates, P.A. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Advanced Spine Associates, P.A. may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards or patient statements. I have the right to request that Advanced Spine Associates, P.A. restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement.

By signing this form, I am consenting to Advanced Spine Associates, P.A. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Advanced Spine Associates, P.A. may decline to provide treatment to me.

_____
Signature of patient or Legal Guardian

_____ _____
Patient Name Date

_____
Print Name of patient or Legal Guardian

Form updated 08/09/2012