

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I _____ understand that as a part my healthcare Colorado Spine Therapy, LLC originates and maintains paper and/or electronic records describing my health history, symptoms upon examinations and test results, diagnosis, 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 by which third party year payer can verify that service billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

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 health care operations

I understand that Colorado Spine Therapy, LLC 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 further understand that Colorado Spine Therapy, LLC reserves the right to change their notice and practices and prior to implementation in accordance with Section 164.520 of the Code of Federal Regulations should Colorado Spine Therapy, LLC change their notice they will send a copy or any revised notice to the address I've provided (whether U.S mail, or if I agree, e-mail).

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

I understand that s 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 fully understand and ACCEPT or DECLINE the terms of this consent.

Patient Signature

Date

FOR OFFICE USE ONLY:

Consent received by: _____

Consent refused by patient and treatment refused as permitted: _____

Consent to the patient's medical record on: _____