Name:_____ DOB: _____

FOUNDATION
PAIN & SPINE

# Consent for Use & Disclosure of Protected Health Information & the Authorization to Release Information

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and my plans for future care or treatment.

**I understand that this information servies as:**

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

**I understand I have the right to:**

- Object to the use of my health information for directory purposes.
- 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.
- Revoke this consent in writing, except to the extent that the organization has already taken the action in reliance therein.

To protect your privacy under HIPAA, we have created this consent form for releasing medical information about you, for treatment, payment, and health care operations, or to family members and other people of your choosing. This will also be used for consent to leave you detailed telephone messages at the mentioned phone numbers. Many times we have patient's family member's call requesting medical information and legally we are not allowed to release that information without the patient's written consent. The purpose of this document is to protect your privacy.

I authorize **FOUNDATION PAIN AND SPINE (FPS)** to furnish requested information from the patient's medical and other records to: (1) any insurance company or third party for purpose of obtaining payment on account of **FPS**, (2) the disability insurance company to expedite my claim, (3) any other person(s) or entities financially responsible for the patient's care or treatment, and (4) representatives of local, state, or federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable disease such as Acquired Immune Deficiency Syndrome ("AIDS"). I also authorize the release of information and /or review of patient's records for purpose of conducting medical audits, utilization reviews, or quality assurance reviews.

I hereby give my permission for the release of medical information regarding appointment and questions about my condition and treatments to the following person(s):

Name:_____ Relation:_____ Phone:_____
□ Financial and Medical Information □ Financial Information only □ Medical Information Only

Name:_____ Relation:_____ Phone:_____
□ Financial and Medical Information □ Financial Information only □ Medical Information Only

Name:_____ Relation:_____ Phone:_____
□ Financial and Medical Information □ Financial Information only □ Medical Information Only

Do you have an Advance Directive/Living Will? □ Yes □ No

I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for the communication of my health information. **I have received a copy of FOUNDATION PAIN AND SPINE'S Noticy of Privacy Practices.**

X_____
Patient's or Authorized Representative's Signature Todays Date