ATLANTIC SPINE CENTER
A National Leader in Endoscopic Spine Surgery

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PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I give permission for Atlantic Spine Center (ASC) to speak with _____ on my behalf in regard to my entire medical files.

I, the patient, hereby give my consent for Atlantic Spine Center (ASC) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by ASC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. ASC 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 ASC at 475 Prospect Avenue, Suite 110, West Orange, NJ 07052.

With this consent, ASC may call my home or alternate location and leave a message on voicemail 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 test results, among others.

With this consent, ASC may mail to my home or alternate 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, ASC may email to my home or alternate location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that ASC restrict how it uses or discloses my PHI to carry out TPO. 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 allow ASC to use and disclose my PHI to carry out TPO.

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

Signature of Patient or Legal Guardian:

Patient's Name _____

Patient _____ Date _____

Name of Legal Guardian (if applicable) _____

Relationship: ❑ Spouse ❑ Child ❑ Parent ❍ Other _____

Patient's Initials: _____

Date: _____ / _____ / _____