Buckeye Spine & Rehab

Consent for Use of Protected Health Information for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Buckeye Spine & Rehab for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations of Buckeye Spine & Rehab. I understand that diagnosis or treatment of me by physicians of Buckeye Spine & Rehab 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. Buckeye Spine & Rehab is not required to agree to the restrictions that I may request. However, if Buckeye Spine & Rehab agrees to a restriction that I request, the restriction is binding on buckeye Spine & Rehab and the treating physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that the treating physician of Buckeye Spine & Rehab 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 the right to review Buckeye Spine & Rehab's Notice of Privacy Practices prior to signing this document. Buckeye Spine & Rehab'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 Buckeye Spine & Rehab. This Notice of Privacy Practices for Buckeye Spine & Rehab is posted in the waiting room of the practice and on the website at **www.buckeyespineandrehab.com**. This Notice of Privacy practice also describes my rights and Buckeye Spine & Rehab's duties with respect to my protected health information.

Buckeye Spine & Rehab reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice or privacy practices by accessing Buckeye Spine & Rehab's website at **www.buckeyespineandrehab.com** calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Buckeye Spine & Rehab

2036 Schorrway Drive Lancaster, OH 43130

Phone: 740-681-1582 Fax: 740-681-1586

PATIENT PRIVACY

Provider Notice of Privacy Practices

I hereby acknowledge that I have been provided a copy of the *Provider Notice of Privacy Practices* or acknowledge that I have read this policy located on the web site or waiting room wall of of Buckeye Spine and Rehab and have reviewed such policy. My signature below indicates that I understand how my health information may be used by Buckeye Spine & Rehab and agree with such policy.

Disclosing Information to Others – Your Consent

I have listed family members or others where I permit Buckeye Spine & Rehab to disclose appointment, prescription information, lab results, billing and other information on my behalf.

Name: ____________________________________ Phone: ______________________________

Name: ____________________________________ Phone: ______________________________

I have listed family members or others where I permit Buckeye Spine & Rehab to only disclose information in medical emergency situations.

Name: ____________________________________ Phone: ______________________________

Name: ____________________________________ Phone: ______________________________

Please send billing statements and other correspondence related to my medical care other than to my home, please send to this address:

____

Street City State Zip

I request all correspondence marked "Confidential" ❑ YES ❑ NO

Can confidential messages, such as appointment reminders, be left on your telephone answering machine or voice mail? ❑ YES ❑ NO

I request to be called about appointments, lab results and other health care information other than my home. I realize that my cell phone is not a secure method of communication and realize my privacy may be compromised by providing my cell phone number. Please contact me at: (___) __________________

Patient Signature:

____

___

Patient Printed Name:

____

___

Date: ___________________

Relationship to Patient if signed by other than patient:____

Do you have Power of Attorney? ☐ YES ☐ NO