TAMPA INSTITUTE FOR
PAIN & SPINE

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

Patient Name:_____

I understand that as part of my healthcare, Tampa Institute for Pain and Spine originates and maintains health history symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatments. I understand that the informations serve as:

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

I understand and have been provided with a Notice of information Practices that provides a more complete descriptions of informations uses and disclosures, I understand that the practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I provided I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how much my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the practice is not required to agree to restrictions requested. I understand that I may revoke this request in writing, except to the extent that the practice has already taken action in reliance thereon.

Notification of Family Members (please share information with):

_____ _____

_____ _____

I request the following restrictions to the use or disclosures of my health information:

_____

_____

_____ _____ _____

Signature of Patient or Legal Representative Print Name Date

_____ _____ _____

Witness Signature Print Name Date

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