

The Spine Institute

Patient Name: _____

Date: _____

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of The Spine Institute's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the content of the Notice. I understand that the Notice is displayed for my reference in the office and on the website: www.spineinstituteindy.com. _____

I authorize the following person(s) and/or entity(ies) to have access to my protected health information. I understand that this may be revoked by me in writing. Further, I permit a copy of this authorization to be used in place of the original. _____

Please circle all that apply and Print their names.

Spouse	Children	Parent(s)	Step Parent(s)	Physician	Ex-Spouse	Coach/Trainer

Other: _____

Consent for Release of Prescription History

I authorize The Spine Institute to access my prescription history from unaffiliated medical providers, insurance companies, and pharmacy benefit managers, to keep my medical record as complete as possible. I understand that my prescription history from other sources may be viewable by the providers and staff within The Spine Institute, and may include prescriptions dating back several years.

My current pharmacy is: _____ located at _____.

My initials certify that I read and understand the scope of my consent and that I realize the access. _____

General Consent to Medical Treatment

I request and authorize The Spine Institute, it's support staff, assistants, and my physician to perform routine medical care and other services as required for my health and well-being. I acknowledge that no representatives, warranties, or guarantees as to the results or cures have been made to me by The Spine Institute, nor have I relied upon any such representatives, warranties or guarantees. I hereby consent to have The Spine Institute communicate with me but not limited to the following: appointment reminders, medications, pre-registration, billing, insurance matters, laboratory results, imaging, test results, and surgeries. The forms of communication can include but are not limited to phone, voice mail, verbal communication, email (encrypted and non encrypted), direct mail, fax, photocopy, or text. _____

My initials certify that I read and understand the scope of my consent. _____

To Protect Patient Confidentiality and Privacy, Electronic Recording is Prohibited in The Spine Institute. This includes but is not limited to Taping Conversations and or Video Taping.

My initials certify that I read and understand that Electronic Recording is Prohibited. _____