

Receipt of Notice of Privacy Practices



7 Vanderbilt Park Drive
Asheville, NC 28803

Patient Name: _____

DOB _____ ACCT # _____ Provider # _____

In the course of providing service to you, our office receives and stores health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. You, the patient, have the right to review such Notice prior to signing this consent form. Carolina Spine & Neurosurgery Center reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If Carolina Spine & Neurosurgery Center does change the terms of its Notice of Privacy Practices, the Patient may obtain a copy of the revised Notice. Patient retains the right to request that Carolina Spine & Neurosurgery Center further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. Carolina Spine & Neurosurgery Center is not required to agree to such requested restrictions; however, if Carolina Spine & Neurosurgery Center does agree to Patient's requested restriction(s), such restrictions are then binding on Carolina Spine Neurosurgery Center.

I have received/read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Carolina Spine and Neurosurgery Center.

Signature of Patient or Authorized Representative

Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Print Name

Relationship to the Patient

Source of Authority