NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT&
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Authorization

Name: _____
Address: _____
Phone: _____
E -Mail: _____
Patient # : _____
Social Security #: _____

SECTION B: To The Patient (Please read the following statements carefully):

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Privacy Officer
Wendy Pizzo
Administrator
1725 N. University Drive #325
Coral Springs, FL 33071
Office: (954) 941-8889 Fax: (954) 941-8848
Email: wpizzo@floridaspineandjoint.com

Right to Revoke.
You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on the consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE: I, _____, have had full opportunity to read and consider the contents of this Consent form and have received a copy of your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____
Relationship to Patient: _____
You are entitled to a copy of this consent after you sign it.

FOR OFFICE USE ONLY
_____ Individual refused to sign _____ Communication barriers prohibited obtaining the acknowledgment
_____ An emergency situation prevented us from obtaining acknowledgement _____ Other

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GETACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH IS IMPORTANT TO **FLORIDA SPINE AND JOINT INSTITUTES.** .

THIS NOTICE COVERS THE FOLLOWING ENTITIES PROVIDING YOUR CARE:

All employees, physicians, physician assistants, nurse practitioners, nurses, administrative staff and any other health care professionals providing you care through FLORIDA SPINE AND JOINT INSTITUTE must abide by this Notice of Privacy Practices. FLORIDA SPINE AND JOINT INSTITUTE may share your information with these covered entities to help them provide medical care to you.

PART 1 – FLORIDA SPINE AND JOINT INSTITUTES' LEGAL DUTY

FLORIDA SPINE AND JOINT INSTITUTE is required by applicable federal and state law to maintain the privacy of your health information according to the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Your health information is anything we have created or received regarding your health or payment for your healthcare. It includes both your medical records and personal information such as your name, social security, address and phone number. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice will remain in effect until were place it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

PART 2- HOW WE MAY USE AND DISCLOSE HEALTHCARE INFORMATION ABOUT YOU

We use and disclose health information about you for treatment, payment and healthcare operations; for example:

Treatment. We may use or disclose your health information to a physician, nurse, or other healthcare professional providing treatment to you.

We may also use or disclose medical information to contact you by phone or email to remind you of treatment or to inform you of test results.

Payment. We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations .We may use and disclose your health information in connection without healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Notice of Privacy Practices

Your Authorization. In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

To Your Family and Friends. We must disclose your health information to you, as described in the Patient Rights of this Notice. We may disclose your health information to a family member, friend or any other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care. We may use or disclose health information to notify, or assist in the notification of (including identifying or locating)a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death.

If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services. We will not use your health information for marketing communications without your written authorization.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect. We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information or patient under certain circumstances.

Appointment Reminders. We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, emails or letters).

PART 3 – PATIENT RIGHTS
Access. You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses, such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page and $10.00 per hour of staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternate format, we will charge a cost-based fee to provide your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

PART 4 – HOW YOU MAY ASK FOR HELP OR COMPLAIN
If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer for FCAAC at the contact information below:

Privacy Officer:
Wendy Pizzo
Administrator
1725 N. University Drive #325
Coral Springs, FL 33071
Office: (954) 941-8889 Fax: (954) 941-8848
Email: wpizzo@floridaspineandjoint.com

OR

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW, HHH Building, Room 509H
Washington, D.C. 20201
T: 866-627-7748 | TTY: 886-788-4989
Online: www.hhs.gov/ocr