



TRIANGLE SPINE AND BACK CARE CENTER

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**Consent to Use and Disclose Health Information
(Treatment, Payment, & Healthcare Operations)**

For Office Use Only
Chart No: _____
Date: _____

Patient: (Please print name) _____

or

Authorized Representative: (Printed name) _____

Time: ___ a.m.
 ___ p.m.

Patient or authorized representative consents to the use or disclosure of individually identifiable health information ("protected health information") by TSBCC in order to carry out treatment, payment, or health care operations to:

- 1) Referring Physician – (may be different than your primary care/family physician)
- 2) Primary Care/Family Physician – (may be different than your referring physician)
- 3) Private Insurance Company or Workers' Comp Insurance Company
- 4) If applicable to Case Manger via Fax
- 5) If applicable to the physician/specialist, which Patient is being referred for treatment purposes

Patient has the right and should review our Notice of Privacy Practices for Protected Health Information (provided to you with this consent form) for a more complete description of the potential uses and disclosures of such information, prior to signing this Consent form.

TSBCC reserves the right to change the terms of our Notice of Privacy Practices for Protected Health Information at any time. If there is a change in terms, you may obtain a revised copy of by requesting a paper copy from the receptionist or the Privacy Officer.

Patient retains the right to request that TSBCC further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. TSBCC is not required to agree to such requested restrictions; however, if TSBCC does agree to Patient's requested restriction(s), such restrictions are then binding.

At all times, Patient retains the right to revoke this Consent and revocation must be submitted to TSBCC in writing. Revocation shall be effective *except* to the extent that TSBCC has already taken action in reliance on the Consent and shall be effective upon the date *received* by the Privacy Officer. The request should contain Patient's printed full name, date of birth, valid driver's license number (give state where issued), social security number (optional, but requested to verify identity), date of request, reason for revocation, and signature submitted to the Privacy Officer.

TSBCC may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that TSBCC is required by law to treat individuals). If Patient (or authorized representative) signs the Consent Form and then revokes Consent, TSBCC has the right to refuse to provide further treatment to the Patient as of the time of revocation (except to the extent that TSBCC is required by law to treat individuals).

I have read and understand this information and have received a copy of this form and I am the patient or am authorized to act on patient's behalf to sign this document verifying Consent to the above stated terms. My signature below consents to the release of my Protected Health Information to the entities described above and as listed on my List of Recipients.

Patient or Authorized Representatives' Signature:

Date: _____ Relationship to Patient:

Describe authority to act on behalf of the patient:

Unless revoked earlier or otherwise indicated, this Consent will remain in effect from the date of signing throughout the duration of Patient's treatment at TSBCC with a reasonable sufficient amount of additional time to fulfill and complete your treatment, payment, and healthcare operations course.