Patient Consent for Use and Disclosure of Your Health Information

We are required under federal law to get your permission before using or giving out your Personal Health Information (PHI) to carry out treatment, payment or office functions. Please look over this consent. If you understand and agree with it's terms, please sign and date this consent below.

If you would like more detailed information of how we can use or disclose your personal health information, please review the "Basic Privacy Notice" before you sign this consent.

The notice is posted as well as a copy is available to take with you. We may change and update our policies and procedures that we refer to in the Notice from time to time. If you would like a revised Notice of Privacy Practices, they may be obtained by forwarding a written request to the Clinic Manager of this practice.

You may ask us to restrict how your personal health information is used or given out in the treatment, payment or office functions. We are not obligated to agree with these restrictions, but if we do agree, these restrictions will be honored.

We will give out personal health information to family or close personal friends who are directly involved in your care unless you tell us otherwise. Please list family members, or other person, with whom we may **NOT** discuss your general medical care, conditions or diagnosis with:

_________________________________ _________________________________

_________________________________ _________________________________

With this consent, The Ohio Neurosurgical Institute, Inc. or members of the office may leave a message containing my Personal Health Information. **The practice may leave messages for me utilizing the following, unless I have indicated otherwise:**

Answering Machine	☐ Do not leave messages on my answering machine
Voice Mail	☐ Do not leave messages on my voice mail
Cell Phone	☐ Do not leave messages on my cell phone
Place of Employment	☐ Do not leave messages at my place of employment

**(I am fully aware that a cell phone is not a secure and private line)*

Information that may be left will include the following examples to assist the practice in carrying out my care, appointment reminders, insurance items and information pertaining to my clinical care, including test results.

I may cancel my consent at any time by putting my request in writing and giving it to the Clinic Manager. The practice will honor my request (except to the extent that the practice has already made disclosures before receiving my notification that I wish to cancel this consent).

By signing this form, I am consenting that I have received a copy of the "Notice of Privacy Practices", have read it, have had my questions answered to my satisfaction, and agree to let the practice use or give out my personal health information to carry out treatment, payment, or office operations as they pertain to me.

If I do not sign this consent, or later revoke or cancel it, The Ohio Neurosurgery, Institute, Inc., may decline to provide treatment to me.

_________________________________ _________________________

Patient Name (please print) **Date of Birth**

_________________________________ _________________________

Signature of Patient or Legal Guardian **Date**

Amended June 2003 - This supercedes any previous form