Name: ____ Date of Birth: _____/________/___________

NOTICE OF PRIVACY PRACTICES

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. Spinal Centers, Inc. has prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information. Spinal Centers, Inc. will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. The terms of the notice may change with time and we will always post the current notice at our facility and have copies available for distribution.

I have reviewed or have declined to review the privacy practice notice for Spinal Centers, Inc. I understand that Spinal Centers, Inc. will properly maintain my records and will use all due means to protect my privacy as outlined in the privacy notice. I understand that this form will be placed in my patient chart and maintained for six (6) years unless I provide written notice to revoke this authorization.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I agree to allow Spinal Centers, Inc. to release information regarding my medical treatment to any private or government insurance program that covers me, including Medicare and Medicaid, as necessary to verify benefits, authorize services and process medical claims. In addition, release of medical records is authorized for my continuing care facility, any organization involved in the discharge planning process, any organization performing utilization review and any health care agency authorized by law.

AUTHORIZED INDIVIDUALS

I hereby authorize medical and/or account information pertaining to me to be disclosed to the individuals listed below. I understand that individuals not listed below will not be allowed to obtain information regarding my medical records and/or account information.

Authorized individuals: ____

Sign Below to Agree to Above Notice:

________________________________ ______________________________ _________________________

Signature of Patient or Representative Printed Name Date

RELEASE OF MEDICAL AND/OR PSYCHOLOGICAL INFORMATION

I hereby authorize medical and/or psychological records pertaining to me to be disclosed to:

Spinal Centers, Inc.

2921 W Michigan Ave	*24 E Nine Mile Rd*
Pensacola FL 32526	*Pensacola FL 3251*
850-434-8880	*850-479-1333*

________________________________ ______________________________ _________________________

Signature of Patient or Representative Printed Name Date

Witness to Patient Signature and Understanding: ______________________________

CONSENT TO TREAT A MINOR:

I hereby authorize and give consent for the Spinal Centers, Inc. to examine, and if needed, treat my minor child ___________________________

Print name of child

Printed Name of Parent of Guardian: ______________________ Signature: ______________________________ Date: ________________________