PATIENT CONSENT FORM

By signing this form, you are granting consent to San Antonio Spine Center to use and disclose your protected health information for the purposes of treatment, payment, and healthcare operations. Our notice of privacy practices provides detailed information about how we may use and disclose this protected health information. You have a legal right to review our notice of privacy practice before you sign this consent, and we encourage you to read it in full.

Our notice of privacy practices is subject to change. if we change our notice, you may obtain a copy of the revised notice by contacting our office: (210)-351-6500.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, and healthcare operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent that we have already used or disclosed your protected health information in reliance on your consent.

Paient Printed Name: ______________________________

Signature: ______________________________ Date: ______________