

HIPAA Patient Consent Form

Spine Institute of Central Florida is required by law to provide individuals with a notice of our legal duties and Privacy Practices with respect to Protected Health Information (PHI). Our Notice of Privacy Practices provides information about how we may use and disclose PHI about you.

The Notice has a Patient Rights section that describes your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to expressly limit the disclosure of your PHI that is not related to payment, treatment or health operations, and such disclosures will not be made without additional authorization from you.

By signing this form, you consent to our use and disclosure of PHI about you. You have the right to revoke this Consent, in writing signed by you, at any time. However, such revocation shall not affect any disclosures that we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You understand that:

- You have the right to expressly limit the disclosure of your PHI that is not related to payment, treatment or health operations, and such disclosures will not be made without additional authorization from you.
- You understand that health information will be used or disclosed to certain business associates who are part of the health care process. These business associates will also keep your health information confidential.
- You may revoke this Consent in writing at any time and all future disclosures that are unrelated to treatment, payment, or health care operations will cease.
- The Practice has a Notice of Privacy Practices and you can obtain a copy of this Notice upon request.
- The Practice is required to maintain the confidentiality of your medical record.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The Practice may condition receipt of treatment upon the execution of this Consent.

Please sign this form to acknowledge receipt of the Notice.

I hereby acknowledge that I have received the HIPAA Notice of Privacy Practices.

This Consent was signed by:

Printed Name – Patient or Representative

Signature

____/____/____
Date

Relationship to Patient (if other than patient)

Witness:

Name

Signature

____/____/____
Date

Patient Consent to Treatment

PURPOSE: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy. This disclosure is not intended to alarm or frighten you, but rather make you better informed so that you may give or withhold your consent to the proposed treatment.

CONSENT TO TREATMENT: I voluntarily request Dr. Okafor as my physician and such associates, assistants, nurses, and other health care providers as he may deem necessary or advisable to treat my condition. I understand that it is my responsibility to actively participate in my care in order to maximize improvement in my condition.

I understand that I may undergo extensive diagnostic tests and examinations during my treatment at the Spine Institute of Central Florida. If I am unable or unwilling to undergo such testing, my treatment plan may be revised and my outcome may be affected. During the course of treatment, I may be required to make frequent follow-up visits to review diagnostic and therapeutic test results. Accommodations for patients traveling significant distances will be made as much as possible, but patients will be required to personally attend office visits for appropriate care and treatment of their condition.

I agree to keep my physician and authorized associate(s) apprised of any changes in my medical condition. Certain diagnostic tests, treatments, and drug therapies can be dangerous under certain medical conditions or medication use. Pregnancy is one such medical consideration and females must be certain to acknowledge this condition prior to diagnostic imaging and initiation of any medication therapy. Female patients who become pregnant during the course of their treatment at the Spine Institute of Central Florida will need to notify their physician.

I understand that treatment of my condition will be directed initially toward conservative management in an effort to avoid surgical intervention, unless I have a condition that medically requires surgery without conservative management. Also, failing conservative care, I may then be considered a potential surgical candidate.

This Consent was signed by:

Printed Name – Patient or Representative

Signature

____/____/____
Date

Relationship to Patient (if other than patient)

Witness:

Name

Signature

____/____/____
Date