Advanced Spinal Care Center
Dr. Michael Polsinelli, DC
6501 Wilson Mills Road Suite B
Mayfield Village, OH 44143
(440) 461-9774

Privacy Consent – For the Use and Disclosure of protected Health Information

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to Dr. Polsinelli & Advanced Spinal Care Center to use and disclose my protected health information for the purpose of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize (this practice), and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health cares professional for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contracting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by the agreement.

I understand that this Practice may refuse my services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take affect until the practice receives it.

Patient/Guardian _____ Date:_____

Printed Name:_____ If not patient, relationship:_____

Copy of Practice Privacy statement signed or initiated with patient/guardian on: _____

Patient unable to sign privacy statement due to: _____

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