WESTCOAST SPINE CENTER

Craig L. Barcomb, D.C.

PATIENT CONSENT FOR USE AND DISCLOUSRE OF PROTECTED HEALTH INFORMATION

With my consent, West Coast Spine Center, may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to West Coast Spine Center's *Notice of Privacy Practices* for a more complete description of such uses and disclosures.

I have the right to review the *Notice of Privacy Practices* prior to signing this consent. West Coast Spine Center reserves the right to revise its *Notice of Privacy Practices* at anytime.

With my consent, West Coast Spine Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care.

With my consent, West Coast Spine Center may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to West Coast Spine Center's use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, West Coast Spine Center may decline to provide treatment to me.

Patient's Signature_____

Patient's Printed Name _____

Date_____