SPARTANBURG NEUROSURGICAL INSTITUTE, P.A.
Authorization of Use and Disclosure of Protected Health Information

<u>Appointment Reminders.</u> The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by mail in a sealed envelope, or, a brief nonspecific message may be left on your answering machine.

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Spartanburg Neurosurgical Institute, P.A.? (check all that apply)

____Regular Mail   _____Home Telephone _____Work Telephone

Other____

If you have an answering machine, may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Spartanburg Neurosurgical Institute, P.A.? (check one)

_____Yes   _____No   _____N/A

If "NO," how else may we contact you regarding this information?

____

Please list any other restriction regarding messages or reminders about your healthcare:

____

<u>Other Uses and Disclosures.</u> Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Policies and Practices" Brochure and/or consent require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restrictions on use and disclosure of your health information.

____I would like the following restrictions regarding the use and disclosure of my health information:

____

____

____

OVER

Persons Authorized to Receive Information:
Health information Spartanburg Neurosurgical Institute, P.A. collects or receives about you may be disclosed to the following persons:

____
Name of person/relation/organization

____
Name of person/relation/organization

Use and Disclosure of Information:

___I authorize the person(s) listed above to receive <u>all health information</u> about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Spartanburg Neurosurgical Institute, P.A.

____I do not authorize the following information to be disclosed to any other parties except to me as the patient. (Please specify):

____

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Spartanburg Neurosurgical Institute, P.A. You should contact the PRIVACY OFFICIAL or other authorized representative to terminate this authorization.

Potential of Re-disclosure
The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under federal privacy regulations.

Signature

____
Name of Patient (print or type)

____
Signature of Patient Date

____
Signature of Patient Representative

____
Relationship of Patient Representative to Patient