



Consent for Use or Disclosure of Health Information

Spinal Rehab and Wellness Center has always been concerned with protecting our patients' privacy. While the law requires us to give you the HIPAA disclosure, please understand that SRWC has and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
- We have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to disclose your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides detailed descriptions of how your health information may be used or disclosed. We reserve the right to change our privacy policy as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come into the office for treatment or by mail. Please feel free to call us at any time for a copy of our privacy policy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You have the right to revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have a right to receive a copy of this notice.

Printed Name

Authorized Provider Representative

Signature

Address:
Spinal Rehab and Wellness Center
3450 Montgomery Road
Suite 21
Aurora, IL 60504

Date

Personal Representative Printed Name

Personal Representative Signature

Effective Date: April 14, 2003