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I. Acknowledgment of Notice of Privacy Practices

The Notice of Privacy Practices tells you how we may use and share your health records.
Please read it.

- We will use and share your health records to treat you and to bill for the services we provide.
- We will NOT use your personal health information for services that you pay for privately.
- We will use and share your health records to operate this medical practice.
- We will use and share your health records as required by law.

NOTE: All the ways we may use and share your health records are explained in more detail in the Notice of Privacy Practices.

You have the following RIGHTS with respect to your health records:

1. You have the right to look at and receive a copy of your health records.
2. You have the right to receive a list of whom we have given your health records to.
3. You have the right to ask for us to correct a mistake in your health records.
4. You have the right to ask that we not use or share your health records.
5. You have the right to ask us to change the way we contact and communicate with you regarding your care and treatment.

NOTE: All of these rights are explained in more detail in the Notice of Privacy Practices.

I have received a copy of Neurosurgery Associates Notice of Privacy Practices

Patient Signature: **X** ______________________________________ Date: ____________________
(or legal representative)

Capacity of Legal Representative (if applicable)*: ____
**May be requested to provide verification of representative status.*

II. Consent

I consent to the use and sharing of my health records for treatment, payment, and operation purposes as described in the Notice of Privacy Practices. I know that if I do not consent, you cannot provide services to me.

Please be advised that the information authorized for disclosure may include information which may be considered a **communicable or venereal disease**, including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). It also may include **mental health** or other sensitive information.

Patient Signature: **X**__________________________________ Date: ________________
(or legal representative)
Capacity of Legal Representative (if applicable)*: _______________________________