PACIFIC BRAIN & SPINE
MEDICAL GROUP

NEUROSURGERY
Lawrence D. Dickinson, MD
Ronnie I. Mimran, MD
Jeffrey B. Randall, MD

MAILING ADDRESS
1320 El Capitan, Suite 300
Danville, CA 94526

OFFICE LOCATIONS
DANVILLE
925-884-2360

CASTRO VALLEY
510-886-3138

LAFAYETTE
925-884-2360
Fax: 510-373-1616

www.pacbrain.com

Authorization for Use of Disclosure of Protected Health Information

Patients Name _____ Birthdate _____
Last four digits of Social Security No. _____

I hereby authorize Pacific Brain & Spine Medical Group, Inc. to use and disclose my individually identifiable health information ("IIHI") with

Name: _____ Relationship: _____
Address: _____
Phone: _____ Fax: _____

Name: _____ Relationship: _____
Address: _____
Phone: _____ Fax: _____

This authorization also covers the following categories of IIHI:

- **Medical Records** (exclusive or psychotherapy notes, mental health records protected by the lnaterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any except as specifically provided below.
- **Claims & Billing Information**

Please limit use and disclosure of my IIHI to the following:

_____

_____

(Examples: "test results March 1988"; "narrative reports related to 1/1/02 date of injury")

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying Pacific Brain & Spine in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by Pacific Brain & Spine in reliance on this authorization before Pacific Brain & Spine receives my request for revocation or modification. I must sign my written request and send it to:

Pacific Brain & Spine Medical Group, Inc.
1320 El Capitan Dr. Suite 300
Danville, Ca. 94526

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship:
____ Parent, guardian or caregiver or a minor patient
____ Beneficiary or personal representative of a deceased patient
____ Guardian or conservator of an incompetent patient
____ Other _____

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HIPAA Acknowledgement/Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____

Signature _____

Signature Date _____

Relationship to Patient (if patient unable to sign) _____