Advance Spine and Pain Physical Therapy, LLC
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HIPAA Confidentiality of Patient Health Information Statement

I consent to the use or disclosure of my protected health information by Advance Spine and Pain Physical Therapy, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Advance Spine and Pain Physical Therapy in accordance with the privacy provisions under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). My agreement shall survive until I am no longer a patient or until I revoke this agreement. I may revoke my consent at any time by written notice. (Your revocation will be effective when we receive it, but it will not apply to any uses/disclosures which occurred before that time).

I understand that diagnosis or treatment of me by Advance Spine and Pain Physical Therapy, LLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Advance Spine and Pain Physical Therapy, LLC is not required to agree to the restrictions that I may request. However, if Advance Spine and Pain Physical Therapy, LLC agrees to a restriction that I request, the restriction is binding on Advance Spine and Pain Physical Therapy, LLC. I have the right to revoke this consent, in writing, at any time, except to the extent Advance Spine and Pain Physical Therapy, LLC has taken action in reliance to this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Advance Spine and Pain Physical Therapy, LLC's Notice to Privacy Practices prior to signing this document. I understand that signing is voluntary. Advance Spine and Pain Physical Therapy, LLC's Notice to Privacy Practices has been provided to me. The Notice to Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Advance Spine and Pain Physical Therapy, LLC. The Notice of Privacy Practices also describes my rights and duties of Advance Spine and Pain Physical Therapy, LLC with respect to my protected health information.

Advance Spine and Pain Physical Therapy, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature Name Date