CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND HEALTHCARE OPERATIONS

PATIENT NAME: _____ DATE OF BIRTH: _____

I understand that as part of my healthcare, SonoSpine, LLC ("SonoSpine") originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, and a tool for routine healthcare operations such as assessing quality.

I understand that a Notice of Privacy Practices that provides a more complete description of information uses and disclosures is available to me. I also understand that SonoSpine reserves the right to change it Notice of Privacy Practices at any time.

I authorize the following persons:

1. _____ Relationship _____

2. _____ Relationship _____

To receive:

- Access to my health records as described above
- Information regarding appointment scheduling, reminders, or changes
- Verification that I am ready to be picked up from my visit or procedure

I request the following restrictions on such authorization, or other uses or disclosures:

_____

_____

_____

I understand that SonoSpine is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing presented to the SonoSpine Clinical Operations Director. I understand that my revocation will not apply to information already released, and that information already disclosed may be re-disclosed by the recipient. I agree and acknowledge to indemnify SonoSpine, including, but not limited to, SonoSpine employees, affiliates, and agents, from any and all damages that result from a release of information in accordance with this consent prior to any revocation.

I authorize SonoSpine to send me reminder notices of upcoming appointments or to leave messages on my telephone answering machine.

I have had the full opportunity to read and consider the contents of this form as well as SonoSpine's Notice of Privacy Practices, and I fully understand and accept the terms of this consent.

_____ _____

Patient's Signature Date

_____ _____

Parent/Guardian's Signature *(if Patient is under 18 years of age)* Date