

LEGACY PAIN AND SPINE SPECIALISTS

HIPAA Notification

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information (PHI).

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have received our notice before signing the consent. You may request a paper copy at any time.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your PHI is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The Health Insurance Portability and Accountability Act (HIPAA) allow for the use of the information for treatment, payment or healthcare operations.

By signing this form I understand that:

- PHI may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the policy as allowed by law.
- The patient reserves the right to restrict the use of PHI but the practice may not agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Yes No **May we phone, email or send a text to you to confirm appointments?**

Yes No **May we leave a message on your voicemail?**

Yes No **May we discuss your medical information with anyone?**

If yes, please name who we may share your medical information with:

Print name: _____ SSN: _____

Signature: _____ Date of Birth: _____

Cell phone: _____ Cell Service Provider: _____

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