

# Pacific Brain & Spine

Medical Group, Inc.

Neurosurgery

20055 Lake Chabot Road, Suite 110  
Castro Valley, CA 94546  
Fax: (510) 351-2425

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

Castro Valley (510) 886-3138  
San Ramon (925) 355-9537

## **CONSENT TO USE AND DISCLOSE INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION**

Pursuant to the requirement found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following is offered for your information and consent. Please be aware that it is this office's policy to require your reading and signing this consent form prior to the provision of treatment or any other medical services. If you have any questions, please ask for the Privacy Official in this office.

I, \_\_\_\_\_, currently residing at \_\_\_\_\_ of  
(city) \_\_\_\_\_, (county) \_\_\_\_\_ (state) \_\_\_\_\_

do hereby consent to the use and disclosure of my individually identifiable health information, ("IIHI") by Pacific Brain & Spine Medical Group, Inc. for the purpose of providing treatment to me, receiving payment from responsible parties for health care services rendered by Pacific Brain & Spine, and/or engaging in health care operations, such as office management, case management and quality assessment.

I understand that Pacific Brain & Spine's Notice of Privacy Practices ("Notice") describes in more detail the types of uses of disclosures of IIHI involved in treatment, payment or health care operations, and that I have a right to review such Notice prior to signing this consent.

I understand that Pacific Brain & Spine has reserved the right to change its privacy practices as described in the Notice. In the event of any change in Pacific Brain & Spine's privacy practices, Pacific Brain & Spine will revise the Notice. I understand that I can obtain a copy of the revised Notice by writing to Pacific Brain & Spine.

I understand that if I choose NOT to sign this consent, Pacific Brain & Spine may withhold medical services, other than emergency services.

I understand that I have the right to request a restriction on Pacific Brain & Spine's use or disclosure of any and/or all health information to any and/or all locations, entities, or persons. I further understand that Pacific Brain & Spine is not obligated to agree to my request. However, if Pacific Brain & Spine does agree to my request, the agreement will become binding.

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Pacific Brain & Spine has relied on this consent, and that any revocation will become effective on the date it has been received by Pacific Brain & Spine and will apply to uses and disclosures of IIHI after the date of receipt.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Patient Signature \_\_\_\_\_