



NOTICE OF PRIVACY PRACTICES

By signing this form, you will consent to our office using and disclosing your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to have a copy of and to read our Notice of Privacy Practices prior to signing this form. It describes treatment, payment, and healthcare operations and the use of your information.

We reserve the right to change our Privacy Practices. A revision notice will be provided upon change. A copy of our Privacy Practice may be obtained at any time by asking the front desk staff.

You have the right to revoke this Consent at any time by giving written notice to our office. Please note that we may decline to treat you if you decline this Consent.

I have read and understand the content of the privacy consent form. I give my consent for this office to use and disclose my personal health information for treatment, payment activities, and healthcare operations.

Patient Name: _____

Signature: _____

Date: _____

Andover Spine and Health Center
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