NEUROSURGERY ASSOCIATES OF KANSAS CHARTERED

Consent to Use and Disclose Protected Health Information for Purposes of Treatment, Payment and Health Care Operations

As a condition of providing treatment to you, NEUROSURGERY ASSOCIATES OF KANSAS must obtain your consent to use and disclose protected health information about you to carry out treatment, payment and health care operations of the office.

You may revoke this consent at any time by notifying our office in writing, except to the extent the office has taken action and reliance on your consent. Your protected health information may be used and disclosed to carry out treatment, payment and health care operations.

Please refer to the Notice of Privacy Practices for Protected Health Information (Privacy Notice) for a more complete description of the uses and disclosures that our office/staff may use of your protected health information. You have the right to review the Privacy Notice prior to signing the consent.

Our office has reserved the right to change its privacy practices described in the Privacy Notice. In accordance with the law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.

You have the right to request the office to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment or health care operations. The office is not required, however, to agree to such requested restrictions. If, however, the office agrees to the requested restriction, our office will honor the request and it will be binding on our office.

I hereby consent to the use and disclosure by the office, its workforce, and its business associates of my protected health information for purposes of treatment, payment and health care operation.

_____

Signature

_____ _____

Signature of Personal Representative of Patient **Date**

_____ _____

Printed Name of Personal Representative **Description of Representative Authority to Act for Patient**

MEDICARE CONSENT TO ASSIGNMENT

I request that payment of authorized Medicare/Medicaid/Champus benefits be made directly to NEUROSURGERY ASSOCIATES OF KANSAS for any services furnished to me by NEUROSURGERY ASSOCIATES OF KANSAS. I authorize any holder of protected health information about me to release to CMS and its agents any information needed to determine these benefits. I authorize my insurance company to furnish the above named doctors any information regarding my claims under the Title XVII of the Social Security Act. I agree that a photocopy of this authorization is as valid as the original.

_____ _____

Patient's Signature **Date**

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Medicare Number

I hereby acknowledge that I have received a Notice of Privacy Policy for Protected Health Information.

_____ _____

Patient's Signature **Date**