ARIZONA NEUROSURGERY
& SPINE SPECIALISTS, P.C.

PATIENT INFORMATION CONSENT FORM

I have read and fully understand ANSS's Notice of Information Practices. I understand that ANSS may use or disclose my personal health information for the purpose of carrying out the treatment, obtaining payment, treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the Company in writing. I also understand that ANSS will consider requests for restriction on a case-by-case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purpose as noted in ANSS's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the Company in writing any time.

I understand that I have the right to various forms (i.e. restriction request, denial of restriction request, designated individuals authorization form, and PHI access request form) at any time upon request if applicable.

_____ _____

Patient's Signature Date & Time

_____

Patient's Name (Please Print)

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