St. Charles Spine Institute

558 St. Charles Drive, Suite 200, Thousand Oaks, CA 91360
(805) 379 2322

Federal and State Laws require that this office keep all x-rays we take on file as a part of the patient's pe1manent records. We take digital x-rays and store them electronically . If a copy of your x-rays is requested a charge of $10.00 will apply and a compact disc will be provided to you.

I have read the above and understand the policy of this office _____ Initials _____ Date

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If you need to have a procedure done, Dr. Nelson has privileges at Los Robles Regional Medical Center and Thousand Oaks Surgical Hospital. Dr. Nelson does surgeries at both of these locations.

I have read the above and understand the policy of this office _____ Initials _____ Date

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HIPAA

Use and disclosure of your protected Health Information

Your protected health information will be used by St. Charles Spine Institute or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health infonnation may be used or disclosed. You may request and receive a copy of the notice at any time.

You may request a restriction on the use or disclosure of your protected health information. St. Charles Spine Institute may or may not agree to restrict the use or disclosure of your protected health inf01mation. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must !·evoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

St. Charles Spine Institute reserves the right to modify the privacy practices outlined in the notice.

Disclosure to Specified Individuals

I give my pennission for my protected health infonnation to be disclosed for the purposes of communication of results, fmdings and care decisions to my family members and others listed below.

Name: Name: -=----------

Name:_____ Name:----------

I have reviewed this consent fonn and give my permission to St. Charles Spine Institute to use and disclose my health information in accordance with it. _____ Initials _____ Date

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I,._____,,_____have read , reviewed and understand the above office policies.

_____ _____

Signature Patient Parent Guardian Date