Ohio Neurology and Headache Centre of Excellence
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CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION

By signing this form you grant Ohio Neurology and Headache Centre of Excellence (ONHC) consent to use and disclose health information for the purpose of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides more details on our treatment, payment activities, and health care operations. If there is not a copy of the Notice accompanying this Consent Form, please request one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed. It also describes certain rights you have regarding your healthcare information.

As stated, in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we should do so, a revised Notice will be issued. Revisions may apply to the health care information we maintain on you, you have the right to receive a copy by contacting our Privacy Officer. Our Privacy Officer can be reached by phone at (614) 760-0666, or by fax at (614) 760-0667.

Under many circumstances, family, friends, or representatives may contact our office on behalf of the patient. According to the HIPPA, consent must be obtained prior to disclosing health care information with anyone other than the patient. Please circle below the individuals we may release health care information on your behalf to:

Mother Father Sibling(s) Son/Daughter

Significant Other Grandparent Other _____

You have the right to revoke this consent in part or in its entirety by giving written notice to our Privacy Officer. The revocation will in no way effect actions that were already taken in reliance upon this consent. You should also understand that if you revoke the consent, we may decline to treat you.

TO BE COMPLETED BY THE PATIENT/PARENT/LEGAL GUARDIAN

I, _____, have read this consent form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose health care information to carry out treatment, payment activities, and health care operations.

_____ _____

Signature of Patient/Parent/Legal Guardian Date