Neurosurgery
Kurt Eichholz, MD, FACS
Peter Sylvester, MD, MHA

Orthopedic Surgery
Robert A. Morgan, MD, FACS

St. Louis Minimally Invasive Spine Center, LLC

Patient Name: ___________________________ Date of Birth: __________________

I understand that St. Louis Minimally Invasive Spine Center, LLC ("Practice") has certain rights and obligations with regard to my protected health information (information regarding my health and treatment that the Practice may have in its possession). I also understand that I have certain rights with regards to my protected health information.

I authorize the Practice to provide informational reminders regarding upcoming appointments I may have to me or anyone who may answer the telephone, or to leave such reminders on any telephone answering device or service, at the telephone number(s) I have provided the Practice as my contact numbers, other than my place of employment. I may also be contacted at the following number(s):
____.

I authorize the Practice to disclose my protected health information to any of the following persons (state name and relationship to you):

____

____

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I understand that I may revoke any authorization granted above by written notice signed by me and delivered to the Practice's Privacy Official at the address stated below. My authorization remains valid until revoked by me in writing.

If I am being treated for a work related injury I acknowledge that I understand agree that my protected hath information may be released or disclosed to any case worker assigned to my care, my insurance company or other payor paying for my treatment, my employer and attorneys or the other persons or entities that may be opposing claims by me for benefits related to my injury.

I acknowledge receipt of the Practice's Privacy Practices Notice effective _________, regarding the Practice's rights and obligations and my rights regarding my protected health information. I acknowledge that I understand and I have the right to request and receive clarifications, explanations, or further information with regards to the Practice's Privacy Practices through written request signed by me addressed to the Practice's Privacy Official.

St. Louis Minimally Invasive Spine Center, LLC
ATTN: Madison Ritchie, Privacy Official
4590 S. Lindbergh
St. Louis, MO 63127

Patient's Signature: ____ Date: ___________