

# COMPREHENSIVE SPINE CARE, P.A.

## COMPREHENSIVE PHYSICAL THERAPY

NOMAAN ASHRAF, M.D.  
Board Certified Adult & Pediatric Spinal Surgery

RAFAEL LEVIN, M.D.  
Board Certified Adult & Pediatric Spinal Surgery

JONATHAN P. LESTER, M.D.  
Board Certified Physical Medicine & Rehabilitation

JAY GREENSPAN, PT, CERT, MDT  
Physical Therapy

### FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information as described below.

1. My authorization applies to the information described below. Only his information may be used and/or disclosed pursuant to this authorization.

\_\_\_\_\_ All information/no restrictions  
\_\_\_\_\_ Restrictions as listed \_\_\_\_\_  
\_\_\_\_\_

2. I authorize the following persons (or class of person) to make the authorized use and/or disclosure of my protected health information.

\_\_\_\_\_ Physician: Ari Ben-Yishay, M.D., Rafael Levin, M.D., Nomaan Ashraf, M.D.,  
Jonathan Lester, M.D., Jay Greenspan, PT, CERT, MDT  
\_\_\_\_\_ Physician Staff: Medical Assistant, Receptionist, Biller, Collectors, Physical  
Therapist

3. I authorize the following persons (or class of persons) to receive my protected health information.

\_\_\_\_\_ Family (please list names) \_\_\_\_\_  
\_\_\_\_\_ No Fault Carriers (Automobile) and adjustors associated with No Fault  
(automobile)  
\_\_\_\_\_ Medical Insurance Company  
\_\_\_\_\_ Workers Compensation including adjusters and case managers associated with  
my case and any insurance claim review companies associated with Workers  
Compensation insurance.  
\_\_\_\_\_ Employer \_\_\_\_\_

4. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

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6. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
7. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons that I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
8. This authorization expires upon 3 years after my last treatment by Comprehensive Spine Care, P.A. and /or Comprehensive Physical Therapy.
9. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Comprehensive Spine Care, P.A., nor will it affect my eligibility for benefits.
10. My protected health information will be used or disclosed upon request for the following purpose.
  - Obtaining authorization for treatment
  - Disability (with proper authorization)
  - Scheduling treatment (hospital, outpatient facility, physical therapy facility, pain management facility, diagnostic facility)
  - Social Security (with proper authorization)
  - Collecting payment for medical services
  - Attorney (when appropriate authorization from attorney is received)
  - Billing for medical services
  - Referral to other physicians by Comprehensive Spine Care, P.A.
11. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed.
12. Changes to the above document must be submitted in writing to Comprehensive Spine Care, P.A. Changes will be effective immediately upon receipt of request.

By signing this form, you are granting consent to Comprehensive Spine Care P.A. and/or Comprehensive Physical Therapy to use and disclosure your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed

466 OLD HOOK ROAD, SUITE 16, EMERSON, NJ 07630, TEL # 201-634-1811, FAX # 201-634-9170

MAILING ADDRESS: P.O. BOX 631, WESTWOOD, NJ 07675

[www.comp spinecare.com](http://www.comp spinecare.com)

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information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling 201-634-1811.

You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name of personal representative

\_\_\_\_\_  
Relationship to patient

If you have any questions, please feel free to speak to any of the staff members.

Thank you,

Comprehensive Spine Care, P.A  
Comprehensive Physical Therapy