SPINE INSTITUTE
OF CENTRAL FLORIDA
WORLD-CLASS SPINE CARE
EXCELLENCE IN MINIMALLY INVASIVE SPINE SURGERY
Comprehensive Center of Excellence in ALL Spine Care & Pain Management

Chukwuka C. Okafor, MD, MBA, CIME
German Marulanda, MD
5050 South Florida Ave. | Lakeland, Florida 33813
1218 Millennium Parkway | Brandon, Florida 33511
Phone: (863) 688-3030 | Fax: (863) 688-4430
www.SpineInstituteFL.com

HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing signed by you, at any time. However, such revocation shall not affect any disclosures that we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent

This Consent was signed by: _____
Printed Name – Patient or Representative

_____ ____/____/____
Signature Date

_____
Relationship to Patient (if other than patient)

Witness: _____
Name

_____ ____/____/____
Signature Date

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Patient Consent to Treatment

PURPOSE: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy. This disclosure is not intended to alarm or frighten you, but rather make you better informed so that you may give or withhold your consent to the proposed treatment.

CONSENT TO TREATMENT: I voluntarily request Dr. Okafor as my physician and such associates, assistants, nurses, and other health care providers as he may deem necessary or advisable to treat my condition. I understand that it is my responsibility to actively participate in my care in order to maximize improvement in my condition.

I understand that I may undergo extensive diagnostic tests and examinations during my treatment at the Spine Institute of Central Florida. If I am unable or unwilling to undergo such testing, my treatment plan may be revised and my outcome may be affected. During the course of treatment, I may be required to make frequent follow-up visits to review diagnostic and therapeutic test results. Accommodations for patients traveling significant distances will be made as much as possible, but patients will be required to personally attend office visits for appropriate care and treatment of their condition.

I agree to keep my physician and authorized associate(s) apprised of any changes in my medical condition. Certain diagnostic tests, treatments, and drug therapies can be dangerous under certain medical conditions or medication use. Pregnancy is one such medical consideration and females must be certain to acknowledge this condition prior to diagnostic imaging and initiation of any medication therapy. Female patients who become pregnant during the course of their treatment at the Spine Institute of Central Florida will need to notify their physician.

I understand that treatment of my condition will be directed initially toward conservative management in an effort to avoid surgical intervention, unless I have a condition that medically requires surgery without conservative management. Also, failing conservative care, I may then be considered a potential surgical candidate.

This Consent was signed by: _____
Printed Name – Patient or Representative

_____ ___/___/___
Signature Date

_____
Relationship to Patient (if other than patient)

Witness: _____
Name

_____ ___/___/___
Signature Date