

**BOZEMAN BACK & NECK CLINIC**  
**120 NORTH 19<sup>TH</sup> AVENUE, SUITE B, BOZEMAN MT 59718**

**DR. RONALD N. HECHT**

**DR. CARSON C. DURR**

**DR. GREGORY P. HOELL**

**CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO  
CARRY OUT TREATMENT, PAYMENT AND/OR HEALTH CARE OPERATIONS**

Through the use of the consent form, **BOZEMAN BACK & NECK CLINIC** (REFERRED TO AS THE OR THIS "OFFICE") is notifying you and you agree that:

1. Protected health information may be used and/or disclosed in order to carry out treatment, payment or health care operations.
2. If you do not consent to the above use and/or disclosure, then this office will not treat you.
3. A notice containing the office's privacy practice, including a more complete description of uses and/or disclosure necessary to carry out treatment, payment and/or health care operations, is available for you to read, and you are hereby encouraged to do so prior to signing this consent form.
4. This office reserves the right to change its privacy practices that are described in the above-referenced notice, in accordance with applicable law, and will make available to all patients any and all revised and current notices.
5. You have the right to request that this office restrict how protected health information is used and/or disclosed to carry out treatment, payment and/or health operations.
6. This office is not required to agree to any restrictions that you have requested.
7. If this office agrees to a requested restriction, then the restriction is binding on the office.
8. You have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that this office has already taken action in reliance on this consent.
9. Should you revoke this consent at any time, the office retains its right to refuse treatment based upon the revocation and the future lack of such consent.
10. I hereby authorize **DOCTORS RONALD N HECHT AND GREGORY P. HOELL**, to use and/or disclose, health information for the purpose of filing my insurance claims & for billing purposes, and to authorize payments to be made directly to the provider.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

\_\_\_\_\_  
Name of Individual (printed)

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Signature of Legal Representative  
(e.g., Attorney-in-fact, Guardian, Parent if a minor)

\_\_\_\_\_  
Relationship

Date Signed \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_  
Witness