

Blue Sky Neurosciences, LLC
Blue Sky Neurology, LLC & Blue Sky Outpatient Neurology, LLC

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Members, Colorado Neurological Institute

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Blue Sky Neurosciences, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bill, including necessary appeals to my health carrier for payment to Blue Sky Neurosciences, or to conduct health care operations of Blue Sky Neurosciences, LLC. I understand that diagnosis or treatment of me by Blue Sky Neurosciences, LLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand a copy of my clinical notes will be sent to my referring and/or my primary care physicians. I further understand that my protected health information (PHI) may not be protected by Blue Sky Neurosciences once released from Blue Sky Neurosciences.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Blue Sky Neurosciences, LLC is not required to agree to the restrictions that I may request. However, if Blue Sky Neurosciences, LLC agrees to a restriction that I request, the restriction is binding on the practice of Blue Sky Neurosciences, LLC.

I have the right to revoke this consent, in writing, at any time, except to the extent that the physicians of Blue Sky Neurosciences or Blue Sky Neurosciences, LLC has taken action in reliance on the consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Blue Sky Neurosciences, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Representative's Authority