Texas Spine Associates

Patient Name: _____ Date of Birth: ____/____/_____

Acknowledge and Acceptance of Privacy Notice and Practice (HIPAA)

I acknowledge I have been given an opportunity to read the offices' Privacy Practice. I give my consent to release personal information for the purposes of treatment, referrals, and payment or healthcare operations and understand that I may withdraw this consent at any time in writing.

I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur, I absolve the office of all liability. I give my consent to fax my records for the purposes of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing.

I also understand that I have the right to request restrictions as to how my health information may be used or disclosed. I understand that I have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Other person (s) permitted to receive my medical records other than listed in the paragraph one:

- ☐ No restrictions – may release information if required to anyone.
- ☐ Restrictions: List who we may release information to regarding your healthcare:

_____

_____

I wish to be contacted in the following manner (Check all that applies):

Home Phone #: _____/_____/_____ Cell #: _____/_____/_____

- ☐ O.K. to leave message with detailed information.
- ☐ Leave message with call back number only.

Work Phone #: _____/_____/_____

- ☐ O.K. to leave message with detailed information.
- ☐ Leave message with call back number only.

Patient (or Guardian) Signature: _____ Date: _____

PLEASE FILL OUT COMPLETELY