Patient Name: _______________________ MRN: __________ Date of Birth: ___________

Acknowledgement of Receipt of Notice of Privacy Practices for AXIS SPINE PLLC

I understand that under the Health Insurance Portability and Accountability Act ("HIPAA"), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or been given the opportunity to receive a copy of the Notice of Privacy Practices of Axis Spine PLLC (the "Practice"). I also understand that the Practice has the right to change its Notice of Privacy Practices and that this updated information is on the company website (www.axisspinecenter.com) and that I may contact the Practice at any time to obtain a current copy of its Notice of Privacy Practices.

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Signature (Patient, Legal Guardian, or Personal Representative) Date

____

Print Name and Relationship (if not Patient)

Authorization for Use and Disclosure of Personal Health Information for AXIS SPINE PLLC

I hereby authorize Axis Spine (the "Practice") to use and disclose my medical and financial information with the person(s) identified below. It is at my request, that the specific information that may be used and disclosed to this person(s), includes any and all of my personal health information in the records of the Practice that pertain to me.

Name ____Relationship ________________________

Name ____Relationship ________________________

Name ____Relationship ________________________

This Authorization shall expire upon the earlier of 1) a written revocation of this Authorization; 2) upon my termination of all services with the Practice; or 3) until the date of ______________________.

I understand that:

*It is my responsibility to inform the Practice of any desired change in this Authorization.

*I have the right to revoke this Authorization at any time by alerting the Privacy Officer, in writing, at 1641 E Polston Ave Ste 101 Post Falls ID 83854, except to the extent the Practice has taken action in reliance of t this authorization prior to receipt of my revocation.

* I have the right to refuse to sign this Authorization. The Practice will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my authorization.

* The person(s) I authorize may not be governed by privacy laws, therefore, information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy law.

____ _______________

Signature (Patient, Legal Guardian, or Personal Representative) Date

____

Print Name and Relationship (if not Patient)