Delta
SPINE AND PAIN CLINIC

HIPAA Privacy Acknowledgement

1. The medical information may be used by the person authorized for medical/surgical treatment, referrals, billing or claims payment, or other purposes.

2. Disclosed information may be used without your authorization in special situations as required by law, public health, communicable diseases, health oversight, in case of abuse or neglect, FDA's request, worker's compensation, and for the purpose of military and national security.

3. I understand that I may revoke this authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this authorization will remain effective until I revoke in writing.

4. You have the right to inspect and copy all protected health information with limitations as governed by law and fees according to the guideline of state of Texas.

5. You have the right to report violation of private records to proper authorities.

6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign the HIPAA privacy authorization form.

7. I have read and understand the information regarding Health Insurance Portability and Accountability Act (HIPAA).

8. I designate, _____, to access & inquire about my protected medical information. This person IS / IS NOT authorized to pick up prescriptions for me in the event of an emergency. (Circle one)

Individual listed is: _____.
Relationship to Patient

Emergency Contact Name and Phone Number: _____.

_____ _____
Signature of Patient or Authorized Individual Date

_____ _____
Printed Name of Patient or Authorized Individual Relationship to Patient

_____ _____
Witness' Signature Date