Mauna M. Radahd, M.D.

Paul Hurd II, M.D. Jason C. Tse, D.O. Andrea Cordova-Ogg, M.D.

HIPAA PRIVACY POLICY ACKNOWLEDGEMENT

I acknowledge that I have received my Health Information Privacy Policy Notice as required by the HIPAA Act of 1996. Further, I understand that I may call Pain Medicine Group at any time and request to speak to the Privacy Officer regarding any aspects of my Protected Health Information (PHI). I understand that Pain Medicine Group may use or disclose my PHI to others only for the treatment, payment or healthcare operations. I understand I have the right to receive copies of my PHI, with certain exceptions, including but not limited to PHI received by our office originating from other practices or physicians.

_____ _____

Print Name Date

_____

Patient Signature

I give my permission to release my PHI to the following individuals and I understand that Pain Medicine Group will release my PHI only to covered entities as detailed in the policy notice and to the following individuals:
(Please Circle and Print Name of Person(s)

My Spouse: _____

My Child(ren): _____

My Parent(s): _____

Other (Please Specify):

_____

_____ _____

Patient Signature Date