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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