***Acknowledgement of Receipt of, and Agreement with, 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"). These practices are acceptable to me. 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.

_____

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

_____

Print Name and Relationship (if not Patient)

**Authorization for Use and Disclosure of Personal Health Information ("PHI") by Axis Spine PLLC**

I hereby authorize Axis Spine ("the practice") and its employees to use and disclose my medical and financial information (PHI) to the person(s) or organizations(s) identified below. It is at my request, that the specific information that may be used and disclosed includes any and all of my personal health and financial information in the records of the practice that pertain to me. ***In addition, I understand that by signing this document, I agree that as part of my physical and emotional health care, my PHI may be disclosed to other clinical providers upon request, as well as to any Health Insurance or other insurance or benefit company or employer (including their agents) from whom I or my family may seek benefits or leave of absence; further, my employer may receive Work Status reports which may contain PHI. I agree to notify Axis Spine PLLC in writing if I wish to exclude any such company or employer from receiving PHI.***

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 7600 N Mineral Drive Ste #700 Coeur d'Alene, ID 83815, 208-457-4208, except to the extent the Practice has taken action in reliance of th 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)

DOB: DATE