
Dr. Terrence L. Piper | Dr. Christopher R. Hemmer
Dr. Theodore S. Rummel

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that Piper Spine Care, P.C. (the "Practice) has certain rights and obligations with regard to my protected health information (information regarding my health and treatment that the Practice may have in its possession). I also understand that I have certain rights with regard to my protected health information.

I authorize the Practice to provide informational reminders regarding upcoming appointments I may have to me or anyone who may answer the telephone, or to leave such reminders on any telephone answering device or service, at the telephone number(s) I have provided (including my cell phone) the Practice as telephone numbers at which I may be contacted (other than the telephone number of my place of employment). The purpose of this consent is to leave messages with members of your household, on your answering machine, or on your cell phone.

_____

(Name of Patient or Personal Representative)

_____

(Signature of Patient or Personal Representative)

_____

(Date)

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give consent to release this information to the family members indicated below. This consent form will not allow Piper Spine Care, P.C. to release any other information to these family members. You have the right to revoke consent in writing. I authorize/allow Piper Spine Care P.C. to disclose my protected health information to any of the following persons:

1. _____ Relation to Patient:_____
2. _____ Relation to Patient:_____
3. _____ Relation to Patient:_____

**Patient Signature:**_____ **Date:**_____

I understand that I may revoke any authorization granted above by written notice signed by me delivered to the Practice's Privacy Official at the address stated below. My authorization remains valid until revoked by me in writing. I acknowledge receipt of the Practice's Privacy Practices Notice regarding the Practice's rights and obligations and my rights regarding my PHI. I acknowledge that I understand that I have the right to request and receive clarifications, explanations or further information with regard to The Practice's Privacy Practices through written request signed by me addressed to the Practice's Privacy Official:
**Piper Spine Care, P.C., Attn: Molly Erlinger, 112 Piper Hill Drive, Suite 6, St. Peters, MO 63376**

**Patient Signature:**_____ **Date:**_____

**Basis of representative's authority to act for patient**: _____