McKinney Spine and Pain Center.
Afaq Kazi, M.D.
Phone: (469)714-0617 Fax: (469)714-0618

HIPPA Privacy Rule Individual Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment or Healthcare Operations (ξ164.506(a))

I____understand that as part of my health care, **McKinney Spine and Pain Center.** originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my health care;
- A source of information for applying my diagnosis and surgical information to my bill:
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with and understand that **Mckinney Spine and Pain Center Notice of Privacy Practices** provides a more complete description of the uses and disclosures of information.

I understand that:

- I have the right to review **McKinney spine and Pain Center. Notice of Privacy Practices** prior to signing this consent;
- That **McKinney Spine and Pain Center.** reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations and that **McKinney Spine and Pain Centr.** is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that **McKinney Spine and Pain Center.** has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

____
____
____

[ ] Accepted [ ] Denied

Signature of Individual or Legal Representative Witness:______________________________
Printed Name of Individual or Legal Representative Witness:____________________________
Date:________________________

HIPPA Privacy Rule Individual Authorization Agreement
Authorization for the disclosure of protected health information
[ξ164.508(a)]

I____ understand that as part of my health care**, McKinney Spine and Pain Center.** originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my health care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with and understand that **McKinney Spine and Pain center Notice of Privacy Practices** provides a more complete description of the information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another party. I have the right to review **Mckinney Spine and Pain Center Notice of Privacy Practices** prior to signing this authorization. I authorize the disclosure of my Protected Health Information, other than for treatment, payment or health care operations, as specified below for the purposes and to the parties designated by me.

PHI Authorized:
All PHI necessary for purposes of my continued treatment
Purpose Authorized:
For my continued treatment
Parties to whom my PHI is authorized to be released:
Those covered entities that **McKinney Spine and pain Center.** considers necessary for my treatment purposes.

I understand that:

- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations by other covered entities;
- I may revoke this consent in writing at any time, except to the extent that Pain Institute of Central Ca., Inc. has already taken action in reliance thereon.

Signature of Individual or Legal Representative Witness:__________________________________

Printed Name of Individual or Legal Representative Witness:______________________________

Date:_____________________________

HIPPA Privacy Rule Receipt of Notice of

Privacy Practices Written Acknowledgement Form

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE [ξ164.520(C)]

I____ understand that as part of my health care, **McKinney Spine and Pain Center.** originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that **McKinney Spine and Pain Center Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information.

I understand that:

- I have the right to review **McKinney Spine an Pain Center Notice of Privacy Practices** prior to signing this acknowledgement;
- That **McKinney Spine and Pain Center.** reserves the right to change their **Notice of Privacy Practices** and prior to implementation of this will mail a copy of any revised notice to the address I've provided of requested.

Signature of Individual or Legal Representative Witness:___________________________________

Printed Name of Individual or Legal Representative Witness:_______________________________

Date:______________________________