HIPAA PRIVACY RULE

Andrea Wolkenberg
PT, MA, CKTI, MCMT

I hereby acknowledge that I have received and read the information documenting my rights as a patient and the responsibilities of SPINE SOLVERS INC. under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient's Name: _____ **Date:** _____
PLEASE PRINT

Patient's Signature: _____

Please list specific family members and/or friends with whom you would like SPINE SOLVERS INC. staff to share and discuss your medical condition, demographic information, diagnosis, and/or financial account, should it become necessary to do so.

Authorized Name: _____
RELATIONSHIP TO YOU

Phone Number/s: _____

Authorized Name: _____
RELATIONSHIP TO YOU

Phone Number/s: _____

Authorized Name: _____
RELATIONSHIP TO YOU

Phone Number/s: _____

Authorized Name: _____
RELATIONSHIP TO YOU

Phone Number/s: _____

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