COLORADO SPINE INSTITUTE

Name of Patient:_____Date of Birth:_____

I hereby acknowledge that I am aware of the Privacy Practices (HIPAA) for the Colorado Spine Institute and a copy is available for my records.

So the physician(s) and/or office staff may address privacy issues, please indicate with whom we may discuss your routine and/or emergent care and treatment:

Spouse:_____Phone number:_____

Family Member(s):_____Phone number:_____

Guardian:_____Phone number:_____

Other:_____Phone number:_____

When we call, may we leave a detailed phone message? ☐ **YES** / ☐ **NO** Phone # _____

Please mark "No" if you do not give authorization for CSI related communication ☐ No

Please mark "No" if you **do not** want our physician or staff to discuss medical care and treatment with anyone other than healthcare providers/representatives. ☐ **NO**

Please Note: If there is any question in regard to diversion, abuse, or misuse of medications, as dictated by Federal and Colorado State Laws, we must cooperate fully with Legal Authorities and regulatory Agencies.

Patient or Representative Signature:_____Date:_____

Relationship of Representative:_____