



Patient Name: _____

PRIVACY NOTICE ACKNOWLEDGEMENT

I ACKNOWLEDGE THAT:

A copy of the Privacy Practices applicable to care I received at Pain Recovery Solutions was made available to me when I was in the office for treatment. I was provided with my own copy of "Pain Recovery Solutions - Privacy Information for Our Patients" and a copy of Patient Rights and Responsibilities for patients of Pain Recovery Solutions, PC.

I understand that other hospital, physicians, laboratories and other health care providers may see my protected health information, but that they are also obliged to protect my privacy rights in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient or Patient Representative Signature

Date

In addition to other medical staff inside or outside this practice who may collaborate on my care, I hereby authorize release of Personal Health Information to the following people in my family, employment or circle of friends:

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____