ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICE

I acknowledge that I was provided a copy of the Notice of Privacy Practices for **S.E. PA Pain Management, Ltd**.

Print Patient Name:_____ D.O.B: _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; Examination rendered to me and claims information. This information may be released to:
[ ] Spouse_____
[ ] Child (ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number: _____
If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
The best time to reach me is (*day*) _____ between (*time*) _____

Signature of Patient: _____Date:_____

*If person signing is not the patient, please print your name and relationship to patient:

Name: _____Relationship: _____

I [patient or representative] request a copy of the Notice of Privacy Practices: Yes ___ No ___

For Office Use:

If patient/representative requested copy of Notice, date copy was provided:
_____
(2016 cars)