PMRC

The Pain Medication and Rehabilitation Center

Notice of Privacy for Protected Health Information

Acknowledgement of Receipt of “Notice of Privacy Practices”

My signature below is an acknowledgement that I have been offered and either received or Personally declined a copy of the Pain Medicine and Rehabilitation Center’s “Notice of Privacy Practices” written in plain language.

The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice’s legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practice and to make changes regarding all protected health information resident at, or controlled by this practice. If changes to the policy occur, this practice will provide me with a revised copy of the Notice of Privacy Practice upon request.

Patient Name: _____

Patient Signature: _____

Date Signed: _____

If Patient is unable to sign, please complete the following:

Name of Patient Representative: _____

Relationship to Patient: _____

Signature of Patient Representative: _____

Date Signed: _____