Northwest Suburban
Pain Center

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have read the Notice of Privacy Practices from the above named practice. In addition, I want the following information to become part of my permanent record. I understand that I can make changes to this document at any time. I also understand that I can request a copy of this document at any time.

I want to authorize leaving messages on my answering machine.

Home: _____Yes _____ No Work: _____Yes _____ No

The staff of Northwest Suburban Pain Center may leave appointment reminder messages with the following people who may answer my home/work phone.

Name: _____

Relationship: _____

I authorize the staff of Northwest Suburban Pain Center to discuss my protected health care information with the following people:

Spouse (name)or Significant Other:

_____

Other Family Members (names):

_____

PATIENT NAME: _____

PARENT OR GUARDIAN (if under age 18): _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____ DATE: ____/____/_____

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