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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVICY 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 a part of my permanent record. I understand that I can make any 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 Cell: Yes No Work: Yes No

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

| Name of Individual | Relationship |
|---|---|
| | |
| | |
| | |

I authorize the staff of Northwest Suburban Pain Center to discuss my protected healthcare information with the following people. (PLEASE PRINT)

| Name of Individual | Relationship | Phone number |
|---|---|---|
| | | |
| | | |
| | | |

SIGNATURE: _____ DATE: _____/_____/_____

Patient or Guardian Name: _____

RELATIONSHIP TO PATIENT: _____