Acknowledgement of Receipt of Notice of Privacy Practices

Please complete all fields, save this file, and email it back to us — or print and bring it to your visit.

Southwest Ohio Pain Institute is required by law to maintain the privacy of your protected health information and to provide you with a Notice of our legal duties and privacy practices. By signing below, you acknowledge that you have been offered a copy of our Notice of Privacy Practices, which describes how your health information may be used and disclosed.

Patient Name

Today's Date

I acknowledge receipt of the Notice of Privacy Practices

☐ Yes ☐ No

COMMUNICATION PREFERENCES

May we leave voicemail messages regarding your care?

☐ Yes ☐ No

May we use your photo for your medical record (e.g. treatment site)?

☐ Yes ☐ No

RELEASE OF INFORMATION

I authorize Southwest Ohio Pain Institute to discuss my health information with the following individual(s), if needed:

Name

Relationship

Phone

Name

Relationship

Phone

SIGNATURE

Patient / Guardian Signature (type full name)

Date