SOUTHWEST OHIO
PAIN INSTITUTE
Patient Care Education Research

Acknowledgement of Notice of Privacy Practices

Patient Name: _____

I have seen a copy of the Notice of Privacy Practices for Southwest Ohio Pain Center, located at the reception desk. I am aware that it details how my health information may be used and disclosed under federal and state laws. I understand that a personal copy of this notice is available upon request.

_____ _____
Patient/ Legal Representative Signature Date

I authorize Southwest Ohio Pain Center, to release my healthcare information to the person/ persons listed below, in addition to referring physician and any other parties as required by Ohio state law.

Name of person	Telephone Number	Date
_____	_____	_____
_____	_____	_____

__ The following information can be left on my answering machine/ voice mail if you are unable to reach me personally: Appointment reminders and call back reminders.

__ I authorize Southwest Ohio Pain Institute to take my photograph to be used in conjunction with their electronic medical records for identification purposes.

__ I agree to submit to a urinalysis for the purpose of testing for drug metabolites. The specimen provided is my own and has not been substituted and no alterations were made.