



Name _____

Date of Birth: ___/___/___

ACKNOWLEDGE OF RECEIPT OF PRIVACY NOTICE

HIPPA guidelines require that we handle your medical records in a safe and secure manor. The office policy concerning this is readily available in our lobby and a copy will be offered to you upon request. By signing this form you acknowledge that you have received or have been offered a copy of the Privacy Notice for North Lakes Pain Consultants.

Full Name _____ Date of Birth ___/___/___ SSN ___-___-___

Please list persons, other than medical professionals, that you allow to have access to your records. This includes persons that will come with you and/or pick up items for you at this office.

| Name | Relationship |
|------|--------------|
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I acknowledge that I have received or have been offered a copy of the attached Privacy Notice.

Signature _____ Date ___/___/___

*If a Personal Representative's signature appears above, please describe Personal Representative's relationship to the Patient: _____