IPI Interventional Pain Institute
Excellence in Pain Management

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT RECEIPT

I have received the Notice of Privacy Practices on this visit or a previous one. I understand I can request another copy at any time.

First Name	MI	Last Name	Date of Birth

Signature of Patient/Parent or Legal Guardian Date

PATIENT RECORD OF DISCLOSURES

IN GENERAL, THE HIPAA PRIVACY RULE GIVES INDIVIDUALS THE RIGHT TO REQUEST RESTRICTION ON DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION (PHI). THE INDIVIDUAL IS ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OR THAT A COMMUNICATION OF PHI MAY BE MADE BY ALTERNATIVE MEANS SUCH AS SENDING CORRESPONDENCE TO THE INDIVIDUAL'S OFFICE OR CELL PHONE, INSTEAD OF THE INDIVIDUAL'S HOME PHONE.

PLEASE CHECK ALL THAT APPLY:

HOME TELEPHONE:

___Leave message with detailed information

___Leave message with call back number only

WRITTEN COMMUNICATION:

___OK to mail to:

___OK to fax to:

WORK TELEPHONE:

___Leave message with detailed information

___Leave message with call back number only

CELL PHONE:

___Leave message with detailed information

___Leave message with call back number only

I GIVE CONSENT TO THIS OFFICE TO RELEASE ANY AND ALL

RESULTS TO THE PERSONS LISTED BELOW:

NAME	RELATIONSHIP	PHONE NUMBER

THIS DOCUMENT WILL BE A PART OF YOUR MEDICAL RECORD

FOR OFFICE USE ONLY: _____

Entered into system by Date