Advanced Pain Institute

Acknowledgement of Receipt of Notice of Privacy Practices

Advanced Pain Institute reserves the right to modify the privacy practices outlined in the notice.

I acknowledge that I have received a copy of the Notice of Privacy Practices for Advanced Pain Institute.

_____
Print Patient Name

_____ _____
Signature of Patient/Patient Representative Date

_____
Relationship to Patient

Release of Information

Persons whom I give permission to disclose any medical or billing information regarding my care (spouse, family, friends, etc..)

_____
Name of person/ Relationship

_____
Name of person/ Relationship

_____
Name of person/ Relationship