UNIVERSITY Pain Clinic

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices gives you information about how we use and disclose medical information about you.

By signing this form, you are acknowledging that you received a copy of our Notice of Privacy Practices.

Patient Name: _____

If signed by patient:

Signature: _____

Date: _____

If signed by personal representative:

Signature: _____

Date: _____

Printed Name: _____

Relationship to Patient: _____

Do Not Fill Past This Point. Internal Use Only

If not signed, reason:

_____ Patient refused to sign
_____ Patient not able to sign (give information below regarding disability, emergency situation, etc.)
_____ Other

Comments: _____

_____

Name of Reviewer: _____ Date: _____

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UPG HIPAA Form Number: 1.5.2
Effective Date: October 1, 2006