



# Florida Gulf-to-Bay Pain Medicine

## PRIVACY PRACTICES ACKNOWLEDGMENT

### ACKNOWLEDGEMENT STATEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

## PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy act gives individuals the right to request a restriction on uses and disclosures of Personal Health Information (PMI). The individual is also provided the right to request confidential communication.

### **I wish to be contacted in the following manner...**

Please check all that apply:

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

OK to leave message with detailed information

OK to leave message with detailed information

Leave message with call back numbers

Leave message with call back numbers

Written Communication

Other \_\_\_\_\_

OK to leave message with detailed information

OK to fax to this number \_\_\_\_\_

Please list the names/relationship of people we can discuss your medical care with:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Relationship