PAIN RELIEF
ASSOCIATES

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose).

Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian Date

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name	**Last four digits of his/her SSN (required)**
Print Name	**Last four digits of his/her SSN (required)**
Print Name	**Last four digits of his/her SSN (required)**

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number:

____OK to leave message with detailed information
____Leave message with call back numbers only

Written Communication Address:

____OK to mail to address listed above
____Mail me at: _____

Work Telephone Number:

____OK to leave message with detailed information
____Leave message with call back numbers only

Fax Communication:

____OK to FAX to address listed above
____FAX me at: _____

OK to E-mail me at: _____

Name of Patient (Print)	**Signature of Patient/Parent/Guardian**	**Date**