Alliance Spine and Pain Centers Notice of Privacy Practices Acknowledgement Form

Patient Acknowledgment of Understanding of Alliance Spine and Pain Centers Notice of Privacy Practices.

Patient's Name: _____ Date of Birth:_____

I understand that Alliance Spine and Pain Centers may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. [* In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt anyone.]

Alliance Spine and Pain Centers has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is available online and in our offices. I understand that I have the right to read the "Notice" before signing this acknowledgement.

Alliance Spine and Pain Centers may update this acknowledgement and "The Notice of Privacy Practices". If I ask, Alliance Spine and Pain Centers will provide me with the most current "Notice of Privacy Practices".)

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law, and requesting communication by specified methods of communications or alternative location.

Alliance Spine and Pain Centers has established procedures that help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgements, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Alliance Spine and Pain Centers by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Alliance Spine and Pain Centers "Notice of Privacy Practice".

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

_____ _____ _____

Patient or legally authorized individual signature Date Time

* Alliance Spine and Pain Centers includes Interventional Spine and Pain Management, PC dba Alliance Spine & Pain Centers its affiliates and subsidiaries.