Patient_________________________________ Date of Birth____/____/____

Patient Acknowledgement of Notice of Privacy Practices

I have been made aware of Ohio Pain & Rehab Specialists Practice Policy to disclosure information.

In the course of patient care, occasionally it may be necessary to leave a message on your voicemail or answering machine at home, work, or on your cell phone. These are numbers that we ask you to provide so that in the event of an urgent need, we may have alternatives to reach you. Your response to the preference below will apply to all alternatives we have at our disposal to contact you.

Please check ONE preference below:

I authorize Ohio Pain & Rehab Specialists, and its employees and affiliates to leave a detailed message regarding my appointment, prescription, and/or financial account information on my recorder/voicemail:

YES [ ] NO [ ]

I hereby authorize Ohio Pain & Rehab Specialists to furnish information to ____.
(Only designate one person)

Relationship___________________________

I understand that this authorization will be in effect until I have notified Ohio Pain & Rehab Specialists in writing to withdrawn this authorization.

Signature____________________________________ Date____/____/____

Witness______________________________________ Date____/____/____