Form #4

Written Acknowledgement of Receipt of The Privacy Practices of Midwest Pain Institute

Print your full name below:

____
Last *First* *MI*

Date of Birth: _______/_______/_______

I hereby acknowledge that I have received the Notice of Privacy Practices of Midwest Institute dated April 14, 2003.

Please provide your signature (or signature of responsible party) on the line below:

X_______________________________________ Date: _______/_______/_______
Signature of Patient or Responsible Party

____
Relationship to Patient

Permission To Disclose Protected Health Information To Those Involved In The Patient's Care And For Notification Purposes

I request that Midwest Pain Institute disclose to the following family members or friends my protected health information that is directly relevant to such person's involvement with my care or payment related to my care. Midwest Pain Institute may also use or disclose this information as necessary to notify the following individuals of my general condition, location or death.

Permission extended to the following individuals:

_______________________________ _______________________________

_______________________________ _______________________________

❑ Check here if you **DO NOT** want your health information accessible to any individuals

X_______________________________________ Date: _______/_______/_______
Signature of Patient or Responsible Party

A copy of this written acknowledgement shall be placed in your medical record.