Acknowledgement of Privacy Statement

I acknowledge receipt of the Notice of Privacy Practice from Restorative Pain Care. I understand that it is my responsibility to read the information provided therein.

Signature____________________________________ **Date_________________**

Release of Information (Including Medical Record Information):

I authorize the Restorative Pain Care to furnish health, demographic, and other information from my medical records to my insurance company, third party payers, case utilization, and managed care review organizations, which may be necessary for Restorative Pain Care to receive payment or obtain authorization for my care. I further authorize health, demographic, and other information from my medical record to be released to any health care provider or institution providing health care to me. Consent is also given for release of information to Restorative Pain Care by any insurer and all other agencies, institutions, or individuals from whom I have received medical services. This authorization does not apply to information specifically protected by state or federal laws or regulations.

___I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:
___Spouse
___Children
___Other
___Information is not to be release to anyone

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call: ___My home __My work ___My cell

If unable to reach me:
___You may leave a detailed message
___Please leave a message asking me to return your call

The best time to reach me is (day) ___________ Between (time): ______________

Signature______________________________________ **Date________________**