

PAIN RELIEF CENTERS

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

This is acknowledgement that _____, on _____
(Patient's Name) (Date)

received a copy of Pain Relief Centers' Notice of Privacy Practices.

Patient's Signature

Legal Representative

Authority to Sign for Patient

Attach a copy of document of authority if not in the patient's records.

Internal Use Only

If this acknowledgement is not signed, please provide a description of your efforts in obtaining the signed acknowledgement and the reason the acknowledgement was not obtained.

Print Name: _____

Date: _____