Michigan Pain Specialists

Patient Name:
DOB:
Age:
Gender:

HIPAA Acknowledgement

Date:

I understand that I have the right to review Michigan Pain Specialists, P.L.L.C. Notice of Privacy Practices prior to signing this consent. I understand that Michigan Pain Specialists, P.L.L.C. reserves the right to change their notice and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations, and the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I understand that I am authorizing the release of all or any part of my medical record for the purposes of treatment, payment, or practice operations. This release may include records containing information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness, and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under a contract for all or part of the medical charges, including but not limited to: Medicare, Medicaid, or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer. The records may be needed in order to process a claim for medical services. I authorize Michigan Pain Specialists, P.L.L.C. to release information needed for billing purposes to entities that may provide services pertaining to my physician visit, such as reference laboratories.

Signature of Patient or Legal Representative _____ Date _____

Printed Name of Patient _____ Witness _____

Release of Medical Information to Family Members
During the course of your treatment it may become necessary to discuss your condition with a family member or family friend. Below, please indicate to whom we may discuss your condition and/or treatment with:

Spouse Name: _____

Family Member Name(s): _____

Friend(s) Name(s): _____

Restrictions
Please do not discuss my treatment with: _____

Documentation of Failure to Obtain Signed Acknowledgement
I presented this Acknowledgement to the patient. The patient refused to provide a signature when requested.

Staff Member Signature _____ Date _____