Orange County Migraine & Wellness Center

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Orange County Migraine & Wellness Center reserves the right to modify the privacy practices outlined in the notice.

Signature
I have received a copy of the Notices of Privacy Practice for Orange County Migraine & Wellness Center

_____
NAME OF PATIENT [PRINT OR TYPE]

_____
SIGNATURE OF PATIENT OR GUARDIAN

_____
DATE

SECURE PHONE OPTIONS

Is there a phone number on which personal health information could be left on your message recording in the event you are not available when we call?

○ **YES** ○ **NO**

If 'YES', what is that number? _____

EXPANDED AUTHORIZATION OPTIONS

Please list any person you would like to authorize to have access to your billing, appointment, or health information [Such as your spouse, caretaker, or other family members.]

Name	**Relationship**
_____	_____
_____	_____
_____	_____

*With the exclusion of information that is protected under State or Federal Law.

IF PATIENT IS A MINOR

Signature of Patient Representative _____

(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient _____

Please note that State and Federal Law provides additional protections for minors and restricts the release of certain patient information to anyone other than the minor patient.