

# ORANGE COUNTY MIGRAINE & WELLNESS CENTER

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

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.