Innovative Spine and Pain Institute
Where pain stops and life begins®

7655 Five Mile Road, Suite 117
Cincinnati, OH 45230
Office: 513.624.7525
Fax: 513.624.0578

Name: _____
Date of Birth: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are legally required to provide you with a copy of our **NOTICE OF PRIVACY PRACTICES** the first time you receive care at Innovative Spine and Pain Institute.

Patient or Patient's Legal Representative: Check appropriate box and sign.

□ I have received a copy of the Notice of Privacy Practices.

□ I do not want a copy of the Notice of Privacy Practices.

_____ _____
SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE Date

_____
RELATIONSHIP TO PATIENT

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize Innovative Spine and Pain Institute to release and discuss information regarding my medical condition and treatment to the following individual. _____.

This authorization remains in effect until revoked by me in writing.

_____ _____
SIGNATURE OF PATIENT ***Date***

Below this line is for staff use only if patient/legal representative has not signed above.

□ Patient or Patient's Legal Representative refused to sign Acknowledgement.

□ Patient or Patient's Legal Representative is unable to sign Acknowledgement.

_____ _____
Innovative Spine and Pain Institute Date