Advanced Interventional
Pain Management, PA

PLEASE READ

Acknowledgement of Privacy Notice

I understand that as a healthcare provider, my physician or the practice's staff may share my medical information for treatment, billing and healthcare business purposes. I acknowledge that I have been informed of how my medical information is used and shared. I understand the organization has the right to change the Privacy Notice at any time. I may obtain a current copy of the notice by contacting the Medical Records Dept. at 336-714-6400, ext. 1018.

My signature below constitutes my acknowledgement that I understand the privacy practices and will contact Advanced Interventional Pain Management with any questions.

____ ______________________

Signature of Patient or Legal Representative **Date**

____ ________________________

Print Full Name **Date of Birth**

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If signed by a legal representative, relationship to the patient:

I was unable to secure a written Acknowledgement of Receipt of Privacy Notice because:

☐ Patient is physically unable to sign acknowledgement because ____________________
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_______________________________________ _________________________________

Signature of provider/employee **Date**

Person(s)/Physician(s) that may have access to my records:

Name:	**Relationship**	**Contact #:**
____________________________	___________	__________
____________________________	___________	__________
____________________________	___________	__________