NORTH GEORGIA PAIN CLINIC, PC
RECEIPT FOR NOTICE OF PRIVACY PRACTICES/
WRITTEN ACKNOWLEDGEMENT FOR HIPAA PRACTICES

I, _____, acknowledge I have been provided a copy of the **Notice of Privacy Practices** and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

For health information disclosure:

I authorize North Georgia Pain Clinic (physicians and staff) permission to discuss and/or disclose my health information with the following person/persons listed below: I understand that my personal health information may be re-disclosed the person(s) or organizations (s) and may no longer be protected by law.

1. _____ Phone: _____Relationship_____
2. _____ Phone: _____Relationship_____
3. _____ Phone: _____ _____Relationship_____

I understand that this information **may include** any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care and evaluations; treatment for alcohol and/or drug abuse; or similar conditions. You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent North Georgia Pain Clinic has acted based on your permission. The following **information *should not* be released:** _____.

For oral communications: Please *initial* the following:

_____ I authorize North Georgia Pain Clinic to leave information on my provided home/cell phone answering machine/voicemail.

_____ I do not authorize North Georgia Pain Clinic (physicians and staff) permission to discuss my medical treatment with any family member or friends.

_____ Patient refused to sign acknowledgement.

Patient Name: _____

SSN # _____ DOB: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____