

# UNIVERSITY PAIN CLINIC

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices gives you information about how we use and disclose medical information about you.

By signing this form, you are acknowledging that you received a copy of our Notice of Privacy Practices.

Name of Patient: \_\_\_\_\_

If signed by Patient:

If signed by Personal Representative:

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

.....  
**For internal office use only:**

If not signed, reason:

- Patient refused to sign                       Other: \_\_\_\_\_  
 Patient not able to sign (give additional information below regarding disability, emergency situation, etc.)

Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Name of Reviewer

\_\_\_\_\_  
Date