Patient ID: _____

Pain Specialists of Greater Chicago Receipt of Notice of Privacy Practices & Patient Information Authorization

I, _____, hereby acknowledge receipt of the PSGC, S.C. Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or will be made available.

I authorize the methods of communication of my protected health information as indicated below. I understand that under the HIPAA guidelines my patient information is kept confidential unless I provide written authorization.

The following person(s) may inquire regarding a medical service or billing statement, pick up records and prescriptions, and take messages pertaining to my health information.

1. _____Relationship _____
2. _____Relationship _____

I authorize PSGC to leave a message or send information regarding my personal health history, such as test results, physician messages, insurance or billing information or appointment information. Please initial each line that you authorize:

_____ Telephone message
_____ with a person listed above
_____ Mail to: ☐ Home ☐ Office
_____ Fax to: ☐ Home ☐ Office Fax number: (_____) _____

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Patient's Name Print Name of Legal Guardian (if applicable)

Policy 1