ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY NOTICE

Shiloh Pain and Primary Care

I acknowledge that a copy of the Red Lion Pain and Primary Care's **Notice of Privacy Practices** which has an effective date of September 1, 2017 is posted in the office and has been made available for me to read, and I understand that a copy is available for me to personally upon request.

I, the undersigned, certify that I have read, understand and agree to the provisions contained within the agreement form. The issues addressed on this form have been fully explained to me. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.

_____ _____

Signature of Patient (or responsible party if patient is a minor) Date

_____ _____

Printed Name of Patient (or responsible party if patient is a minor) Relationship to Patient

---

PERMISSION TO RELEASE DIAGNOSTIC/MEDICAL INFORMATION TO ANOTHER INDIVIDUAL

I give Red Lion Pain and Primary Care entities permission to release diagnostic test results to, and discuss protected health information with, the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I give Red Lion Pain and Primary Care entities permission to leave any protected health information on an answering machine or voicemail.

☐ Yes ☐ No

By signing this form, I give Red Lion Pain and Primary Care entities permission to send office correspondence to the address provided.

Indicate your relationship to the patient: ☐ Patient ☐ Other: _____

Patient Name: _____ Patient's DOB: _____

Signature: _____ Effective Date: _____

Print Name (if other than patient): _____

This form is good for one year from effective date.