PAIN CARE SPECIALISTS OF FLORIDA
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NOTICE OF PRIVACY PRACTICES

We keep a record of the health care services we provide you. You may ask to see a copy that record. We will not disclose you record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting The Office Manager.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

May we leave a message on your home recorder? YES_____ NO_____

May we leave a message with people at your house? YES_____ NO_____

May we discuss your test results with members of your family? YES_____ NO_____

Please list family members with whom we may discuss test results.

Name_____ Relationship_____

Name_____ Relationship_____

By my signature below I acknowledge acceptance of the Notice of Privacy Practices.

_____ _____
Patient or Legally Authorized Individual Signature Date

Relationship to Patient

Parent ☐ Legal Guardian ☐ Personal Representative ☐

_____ _____
Print Name if Signed on behalf of the Patient Date

This form will be retained in your medical record.