

Garden State Pain Control, PA

Patient _____

Date of Birth ____/____/____

Patient Acknowledgement of Notice of Privacy Practices

I have been made aware of Garden State Pain Control, PA Specialists Practice Policy to disclosure information.

In the course of patient care, occasionally it may be necessary to leave a message on your voicemail or answering machine at home, work, or on your cell phone. These are numbers that we ask you to provide so that in the event of an urgent need, we may have alternatives to reach you. Your response to the preference below will apply to all alternatives we have at our disposal to contact you.

Please check ONE preference below:

I authorize Garden State Pain Control, PA Specialists, and its employees and affiliates to leave a detailed message regarding my appointment, prescription, and/or financial account information on my recorder/voicemail:

YES []

NO []

I hereby authorize Garden State Pain Control, PA to furnish information to _____
_____. (Only designate one person)

Relationship _____

I understand that this authorization will be in effect until I have notified Garden State Pain Control, PA in writing to withdraw this authorization.

Signature _____

Date ____/____/____

Witness _____

Date ____/____/____