



Patient Information Acknowledgment Form

I have read & fully understand Prevent The Pain Therapy, Inc.'s Notice of Information Practices. I understand that Prevent The Pain Therapy, Inc. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice.

I also understand that Prevent The Pain Therapy, Inc. will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use & disclosure of my personal health information for purposes as noted in Prevent The Pain Therapy, Inc.'s Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing.

Patient Name: _____

Signature: _____

Date: _____

I also authorize Prevent The Pain Therapy, Inc. to use my protected health information for targeted marketing, fund raising, and/or solicitation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

Patient Name: _____

Signature: _____

Date: _____