



Thomas E. Runyan, M.D.

### Patient Acknowledgement Form

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**SSN:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

I understand that the patient's health information is private and confidential. I understand that Consultant's in Pain Medicine works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Consultant's in Pain Medicine may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care options. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that there may be situations where Consultants in Pain Medicine is required by law to release this information without my permission. One example would be if a patient threatened to hurt someone.

Consultants in Pain Medicine has a detailed document called the *Notice of Privacy Practices*. It contains more information about the policies and practices protecting the patient's privacy including other potential disclosures and uses of patient's health information. I understand that I can receive a copy of this document at any time of my choosing. One example would be disclosure of health information for research purposes. I understand that I have the right to read the *Notice of Privacy Practices* before signing this acknowledgement.

Consultants in Pain Medicine may update this acknowledgement and *Notice of Privacy Practices*. If I ask, Consultants in Pain Medicine will provide me the most current *Notice of Privacy Practices*.

Within this *Notice of Privacy Practices* is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative locations.

Consultants in Pain Medicine has established procedures that help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgements, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Consultants in Pain Medicine by following these procedures if I choose to exercise any of my rights described in the *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review a current copy of Consultant's in Pain Medicine's *Notice of Privacy Practices* at my discretion.

\_\_\_\_\_  
**Patient or legally authorized signature**

\_\_\_\_\_  
**Date**

**Relationship to patient:** \_\_\_\_\_