EASTERN
Headache & Spine

Acknowledgement of Receipt of Notice of Privacy Practices

Please Note: In calling our physicians or office for medical information, we need to speak with the patient directly unless it is an emergent situation. **Any person calling for you should be able to identify your date of birth, physician name, and problem or procedure performed.** This enables us to further protect your right to privacy.

List any family members or friends (not your doctors) to whom your health information may be disclosed:

_____

_____

We will disclose all pertinent health information about you to those listed above with the following limitations:

_____

_____

This authorization is effective through ___/___/___ unless revoked or terminated by the patient or the patients' personal representative in writing by contacting the medical records department at 252-215-3067 ext. 104. If left blank, authorization will end 2 years from signed date.

- I have received or was offered a copy of the Notice of Privacy Practices for Eastern Headache & Spine.
- I understand that this practice has the right to modify or change its privacy practices and that I may obtain any revised notices from the practice, upon my request. All revisions would remain HIPPA compliant.
- I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction(s), it must follow the restriction(s).
- I also understand that I may revoke this consent at any time by making a request in writing and submitting it to the medical records department, except for information already used or disclosed. Medical Records can be reached at 252-215-3067 ext. 104.

If signed by a patient representative, state relationship to patient: _____

(Signature of patient representative is required if patient is a minor or an adult who is unable to sign this form).

Signature: _____ **Date:** _____

MEDICARE - ONE TIME SIGNATURE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Eastern Headache & Spine for any services furnished to me by the physician(s). I authorize any holder of medical information about me to release any and all information requested to the Health Care Financing Administration and its agents as needed to determine these benefits or the benefits payable for related services.

Signature: _____ **Date:** _____