A division of Eastern Carolina Anesthesia Associates, PLLC

Notice of Privacy Practices Acknowledgement Form

I received a copy of the Notice of Privacy Practices and understand that the notice describes certain rights I have under federal and state law and discusses how my medical information may be used by Midtown Pain and Spine Clinic.

I have been given an opportunity to ask questions about the Notice.

_____________________________ _______________________

Patient Signature Date

HIPPA Consent

Please list the names of any person with whom we may communicate regarding your medical care:

NAME:	RELATIONSHIP TO YOU:
_____________________________________	___________________________
_____________________________________	___________________________
_____________________________________	___________________________
_____________________________________	___________________________

____________________________________ ________________________

Patient Signature Date