Notice of Privacy Practice Receipt

By signing this form, you are granting consent to the Capital District Interventional Spine and Rehabilitation, PLLC, to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have legal right to review our Notice of Privacy Practices available on our website: www.capitalspine.net, before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website or contacting our organization at 518-487 4093, requesting a copy from our staff member.

I acknowledge that I was provided with the Notice of Privacy Practices of the Capital District Interventional Spine and Rehabilitation, PLLC.

Print name of Patient: ___________________________________DOB_____________

Signature of Patient: ____________________________________Date_____________

For Personal Representative of Patient (If Applicable)
Print Name of Personal Representative of Patient: ________________________________

Describe Personal Representative Relationship: _________________________________

Signature of Personal Representative Relationship: _____________________________
Date: _______________

For Practice Use Only: