Receipt of Notice of Privacy Practices, Patient Rights, Advanced Directives and Ownership

I, _____ (Name of patient or authorized agent), hereby give my consent to Great River Pain Center to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient records of _____. (Patient Name)

I acknowledge receipt of the organization's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I acknowledge receipt or the organization's Patient Rights, Advanced Directives and Ownership Disclosure.

I understand that the organization has reserved a right to change and/or modify either document as needed. I also understand that a copy of either revised document will be made available at my next scheduled appointment or by request.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the organization has already relied on it to use or disclose my health information. Written revocation of consent must be sent to 555 N Kellogg St, Galesburg IL, 61401

Signed: _____ Date: _____

If you are not the patient what is your relationship to the patient?

_____