Align Interventional Pain
E. MORGAN POLLARD, M.D.

Patient Name: _____ Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices for Align Interventional Pain:
I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or been given the opportunity to receive a copy of the Notice of Privacy Practices of Align Interventional Pain (the "Practice"). I also understand that the Practice has the right to change its Notice of Privacy Practices and that this updated information is on the company website www.alignpain.com and that I may contact the Practice at any time to obtain a current copy of its Notice of Privacy Practices.

_____

Signature (Patient, Legal Guardian, or Personal Representative) Date

_____

Print Name and Relationship (if not Patient)

Authorization for Use and Disclosure of Personal Health Information for Align Interventional Pain:
I hereby authorize Align Interventional Pain (the "Practice") to use and disclose my medical and financial information with the person(s) identified below. It is at my request, that the specific information that may be used and disclosed to this person(s), includes any and all of my personal health information in the records of the Practice that pertain to me.

Name _____Relationship _____ Name
_____Relationship _____ Name
_____Relationship _____

This Authorization shall expire upon the earlier of 1) a written revocation of this Authorization; 2) upon my termination of all services with the Practice; or 3) until the date of _____.

I understand that:
*It is my responsibility to inform the Practice of any desired change in this Authorization.
*I have the right to revoke this Authorization at any time by alerting the Privacy Officer, in writing, at Dr. Pollard's office locations, except to the extent the Practice has taken action in reliance of this authorization prior to receipt of my revocation.
* I have the right to refuse to sign this Authorization. The Practice will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my authorization.
* The person(s) I authorize may not be governed by privacy laws, therefore, information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy law.

_____ _____

Signature (Patient, Legal Guardian, or Personal Representative) Date

_____

Print Name and Relationship (if not Patient)