Mark A. Ellis, MD
Board Certified Pain Management Specialist

Terrance L. Hughes, MD
Board Certified Pain Management Specialist and PM&R

Privacy Practices Acknowledgement

I have had the opportunity to read and review the content of this authorization form and I agree with all statements made in this authorization. By signing this form, I understand that I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations in this form.

_____ _____
Patient Signature Date

I herby give authorization for the person(s) below to obtain any medical records and/or health information pertaining to myself:

_____
Name of Person(s)

_____
Relationship to Patient

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.
Submit the authorization to the Privacy Official and include a copy in the individual patient's medical record.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____
Patient Name Date of Birth

_____
Patient Signature

_____
Date