Hillside Pain Management
York Adams Pain Specialists

Patient's Name: _____

I acknowledge that I have been made aware of the provider's "Notice of Privacy Practices" which sets forth this groups' privacy practices and my rights regarding the privacy of my protected health information and understand that a copy of these practices will be made available upon request.

_____ _____

Patient or Patient Representative Signature Date

If Patient Representative's signature appears above, please describe their relationship to the patient:

_____

Please list the family members or other persons that we may contact in case of emergency and whom we may inform about your general medical condition and your diagnosis:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

I authorize the following persons to pick up prescriptions on my behalf:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This practice may use my voicemail to leave any necessary messages.

□ Yes □ No