I. Acknowledgement of Practice's *HIPAA Privacy Notice:*

By subscribing my name below, I acknowledge that Elyaman medical Service PA, DBA Central Florida Interventional Pain has provided a copy of the HIPAA Privacy Notice, and that I have read (or had the opportunity to read if so chose) and understand my rights and ask questions regarding my rights and receive answers to my satisfaction and agree to its terms.

II. Designation of Caregivers as my Personal Representative:

I give permission for the following person(s) to pick up prescriptions and or any of my personal health information, to include super sensitive information on my behalf. I understand that no prescriptions will be released other than to the person(s) listed below.

***Please Note** - Person(s) listed below will be required to present driver's license or other state/federally issued photo ID when picking up prescriptions, billing information, and/or any personal health information.

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Phone:_____	Phone:_____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home *I* Cell Telephone Number:

OK to leave message with detailed information

Leave message with call back numbers only

Written Communication Address:

OK to mail to address listed above

E-mail me at:

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Work Telephone Number:

OK to leave message with detailed information

Leave message with call back numbers only

Fax Communication Number:

OK to fax to the number listed above

Print name of signer

Signature Date

Elyaman Medical Services, PA DBA Central Florida Interventional Pain Clinic
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