ADVANCED INTERVENTIONAL
PAIN CONSULTANTS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE
USE & DISCLOSURE OF PHI

I **(name)**_____ understand that as part of my health care, Jaime Robledo M.D. maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

I understand that Jaime Robledo, M.D. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand Jaime Robledo, M.D. reserves the right to change their notice and practices and prior to implementation's, in accordance with Section 164.520 of the code of Federal Regulations. Should Jaime Robledo, M.D. change their notice, they will send a copy of any revised notice to the address I have provided (whether by U.S. mail or if I agree via email).

I understand that as part of this organization's treatment, payments, or health care operations it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax or protected E-mail.

I fully understand and accept or decline the terms of this consent.

_____ _____

***Signature* of Patient or Legal Representative** **Date**

FOR OFFICE USE

We attempt to obtain written acknowledgement of this form, but couldn't be obtained because:

☐ Patient/representative refused to sign ☐ Communication barriers

☐ Emergency situation ☐ Other (Specify)_____