COMPREHENSIVE CENTERS
FOR PAIN MANAGEMENT

WEST CENTRAL SURGICAL CENTERS

Notice of Privacy Acknowledgement

Patient Name:_____
Printed Name

I understand and acknowledge the receipt of the Health Insurance Portability and Accountability Act (HIPAA).

Signature:_____

Date:_____

Patient is unable/unwilling to sign for the following reason:

_____
_____
_____
_____
_____

☐ Notice of HIPAA was given to patient. (Please check)

Employee signature:_____

Date:_____