Acknowledgement of Receipt of Notice of Privacy Practice

Orange County Migraine & Headache Center reserves the right to modify the privacy practices outlined in the notice.

Signature
I have received a copy of the Notices of Privacy Practice for
Orange County Migraine & Headache Center
Name of Patient (Print or Type):_____
Signature of Patient:_____
Date:_____

Secure Phone Options:
Is there a phone number on which personal health information could be left on your message recording in the event you are not available when we call? Y N

If 'YES', what is that number? _____

Expanded Authorization Options:

Please list any persons you would like to authorize to have access to your billing, appointment or health information* such as your spouse, caretaker or other family member:

Name	**Relationship**
_____	_____
_____	_____
_____	_____

*With the exclusion of information that is protected under State or Federal Law.

If Patient is a minor:
Signature of Patient Representative:_____
(Required if the patient is a minor or an adult who is unable to sign this form)
Relationship of Patient Representative to Patient:_____

Please note that State and Federal Law provides additional protections for minors and restricts the release of certain patient information to anyone other than the minor patient.