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RECEIPT OF NOTICE OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGEMENT FORM

I, \_\_\_\_\_ (patient), have received a copy of PACIFIC PAIN  
MEDICINE CONSULTANT'S Notice of Privacy Practices.

SIGN AFTER RECEIVING HIPPA LAWS AT YOUR SCHEDULED APPOINTMENT.

I authorize Pacific Pain Medicine to discuss the below indicated topics with the following  
individuals:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

- Billing related topics, including balance, payments, and inquires.
- Prescriptions and dosage
- Appointments ,pre-op instructions, post-op calls
- Medical Records

Please note if a family member or attorney requests the above information without your written  
authorization or a subpoena we will not release any of the above information.

\_\_\_\_\_  
PACIENT SIGNATURE

DATE: \_\_\_\_\_

10/8/2007AS