Oregon Spine Care

Date: _________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge and agree that I have received a copy of Oregon Spine Care notice of Privacy Practices.

Patient Name: ____

Patient Signature: ____

Patient Legal representative_____________________________________

I authorize the people named below to have access to my medical information from Oregon Spine Care.

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Oregon Spine Care made a good faith effort to obtain the above referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices.

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