CASCADE
SPORT AND SPINE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION OF RELEASE OF SPECIFIC INFORMATION

Patient Name:_____ Clinic:_____

Cascade Sport and Spine Rehabilitation reserves the right to modify the privacy practices outlined in this notice.

I acknowledge that I have received or have had the opportunity to receive a copy of the official Notice of Privacy Practices from Cascade Sport and Spine Rehabilitation, Inc.

Signature:_____ Date:_____
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

Initial all statements that apply:

_____I authorize you to leave messages regarding my appointments on my answering machine or voicemail as listed on my patient information.

_____I authorize you to discuss my appointments with my spouse as listed on my patient information.

_____In addition to my referring doctor, I authorize you to communicate with and send reports & evaluations to the following:

_____

_____

_____

By signing this authorization, I understand that this does not authorize release of medical information by Cascade Sport and Spine Rehabilitation, Inc. to any other organization or agency unless I grant further authorization. I also understand that these authorizations may be revoked at any time.

Signature:_____ Date:_____
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self☐ Mother ☐ Father ☐ Legal Guardian