Ashish Udeshi, M.D. | Michael Esposito, M.D.
Thaiduc Nguyen, D.O. | Sherin K. Fetouh, M.D.
Board Certified Anesthesiology and Pain Medicine

Print Patient's Name: _____

****** This authorization will expire one year from date signed. ******

I. Acknowledgement of Practice's *HIPAA Privacy Notice*:

By subscribing my name below, I acknowledge that Tampa Pain Relief Centers, DBA Florida Pain Institute has provided a copy of the HIPAA Privacy Notice, and that I have read (or had the opportunity to read if I so chose) and understand my rights and ask questions regarding my rights and receive answers to my satisfaction, and agree to its terms.

II. Designation of Caregivers as my Personal Representative:

I give permission for the following person(s) to pick up prescriptions and or any of my personal health information, to include super sensitive information on my behalf. I understand that no prescriptions will be released other than to the person(s) listed below.

***Please Note** – Person(s) listed below will be required to present driver's license or other state/federally issued photo ID when picking up prescriptions, billing information, and/or any personal health information.

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

III. Request to Receive Confidential Communications by Alternative Means:
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home / Cell Telephone Number:

_____

_____OK to leave message with detailed information
_____Leave message with call back numbers only

Written Communication Address:

_____

_____OK to mail to address listed above
_____E-mail me at: _____

Work Telephone Number:

_____

_____OK to leave message with detailed information
_____Leave message with call back numbers only

Fax Communication Number:

_____

_____OK to Fax to the number listed above

_____
Print Name of Signer

_____ _____
Signature Date

***** If representative is a court appointed legal guardian, a copy of court documents *****
***** must be provided and kept in medical records. *****