

**RIVERSIDE SPINE &
RIVERSIDE SURGICAL CENTER**

UNIVERSAL ACKNOWLEDGMENT OF NOTICES

I hereby acknowledge that I have received a copy of the following notices:

- X 1. Patient's Bill of Rights and Responsibilities
- X 2a. Ownership Notice to Patients
- X 2b. Notice of Policy Regarding Advanced Directives
- X 3. Notice of Health Information Practices, Amended 02/11/09

I have been presented with a copy of Riverside Spine and Pain Physicians' **Notice of Health Information Practices, amended 2/11/09**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Patient's Signature

Date

Patient's Name, Printed