


## Acknowledgement of Receipt of Notice of Privacy and Consent for E-Prescribing and Medication History

**Directions:** If filling out the form on your computer, save the file and then attach the form to an email and send to [patientforms@pisapain.com](mailto:patientforms@pisapain.com). If filling out the form on your phone, forward as an email (using the  icon) and email to: [patientforms@pisapain.com](mailto:patientforms@pisapain.com). You can also print the forms to write the answers, then scan or take a photo of the forms and email to [patientforms@pisapain.com](mailto:patientforms@pisapain.com).

I hereby acknowledge receipt of a notice of Privacy Practices from the Pain Institute of Southern Arizona (PISA) P.C.

I understand that as a part of my electronic health records, PISA will transmit my prescriptions electronically as permitted to the pharmacy that I designate as my primary pharmacy provider. Additionally, PISA will obtain the history of my past prescriptions from pharmacy benefit managers and I understand that those prescriptions will become a part of my electronic health records. By signing below, I hereby give consent to the above actions.

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Patient Name / Authorized Representative

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Date

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Authorized Relationship to Patient (if applicable)

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Witness Name

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Date

Unable to obtain acknowledgement of receipts of Notice of Privacy Practices because:

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