



Acknowledgement of Receipt of Notice of Privacy Practices  
Pinnacle Anesthesia Consultants, P.A.  
Pinnacle Consultants, L.P.  
Pinnacle Pain Medicine

I received a copy of the Notice of Privacy Practices from the above noted entities.

Signature: Robert Plack

Date: 05/23/2013

Print Name: Robert Plack

Personal Representative: \_\_\_\_\_

If personal representative, please note relationship to patient: \_\_\_\_\_

Prescription Pick-up Authorization

If you would like to give consent for another individual to pick up your prescriptions or documentations, please provide that name below:

Clarence Abner

I give consent for my provider to discuss my medical care with the persons listed below.

Name: Clarence Abner Relationship: Close friend

Signature: Robert Plack 05/23/2013  
(Authorized Representative must present valid photo ID upon pick up)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_  
(Authorized Representative must present valid photo ID upon pick up)

FOR OFFICE USE ONLY

By: \_\_\_\_\_

K. Leal

Date: \_\_\_\_\_

5.24.13