# Acknowledgement of Receipt of Notice of Privacy Practices
# Authorization for Practice to Utilize Information as Described in Privacy Notice
# Patient's Consent for Practice to Share Protected Health Information with Other Named Parties

I hereby acknowledge that I receive a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

Name of Patient: _____

Please indicate by signature below that you are authorizing us to use private patient information as indicated in our Notice of Privacy Practices. This is not a change in how we have historically used your information. New laws require us to disclose how we use this information.

Signed: _____ Date: _____

In addition to our normal operational disclosures of privacy information please identify to whom we may release your healthcare information. Each name must be identified. These should be people who help you with your healthcare needs and may need to be knowledgeable about your condition, treatment and options. The below listed are also authorized to accompany the patient to appointments.

It is still the responsibility of the below named parties to request this information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Updated December 2015