

Written Acknowledgement Form

Our notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I, _____ (Please print patient name) have been provided a copy of the Medical Practice's Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to the Medical Practice if I do not understand any information contained in the Notice of Privacy Practices.

Patients Signature

Date

Authorized Representative of Patient

Relationship to Patient

Date

Disclosures to Family Members and Friends

Place on inside flap of medical record

PATIENT'S SIGNATURE REQUIRED CONCERNING MESSAGES LEFT

I have explained to the Patient, _____, that disclosures may be made to family and friends related to the patient's health or as needed for payment of health care services. I have explained that we will only disclose information relevant to current treatment. Our patient, has agreed that we may disclose health care information to :
(check all that apply)

In person with patient

By phone

Spouse Name _____

Parent(s) Name _____

Sibling(s) Name _____

Other:

Relationship

Name

I give my permission to leave messages on my answering machine regarding appointments, timing of procedures, test results, including pathology reports.

YES

NO

Patient Signature

Date

