ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

** You may refuse to sign this acknowledgement**

I, _____(*please print*), have received a copy, and /or have viewed and read that copy displayed in office of the Notice of Privacy Practices.

Patient Signature: _____

Date:_____

AUTHORIZATION TO RELEASE INFORMATION

Purpose: This form is used to obtain authorization to release information regarding yourself, covered under the Privacy Act to people other than yourself.

I, _____(*please print*), authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

NAME (*printed*)_____RELATIONSHIP_____

NAME (*printed*)_____RELATIONSHIP_____

NAME (*printed*)_____RELATIONSHIP_____

NAME (*printed*)_____RELATIONSHIP_____

NAME (*printed*)_____RELATIONSHIP_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign (*check one*)

____ Communication barriers prohibited the acknowledgement.

____ An emergency situation prevented us from obtaining acknowledgement.

____ Other (*please specify*)