Patient Name: ________________________

Please tell us with whom we may discuss your/patient's treatment, payment or healthcare operation:

{ } SPOUSE____________________________, { } CHILDREN___________________________
{ } RELATIVES____
{ } FRIENDS/CAREGIVERS____
{ } OTHERS____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (July 14,2014 Notice)

I understand that as part of treatment, payment or healthcare operations, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and accept the information on this consent.

____ ________________________________

Patient/Guardian Signature **Print name of person signing**

*If you are not the patient signing; are you the legal guardian, custodian or have ***Power of Attorney*** for the patient, for treatment, payment or healthcare operations.

Yes { } **No { }**

Date: _________________________

FOR OFFICE USE ONLY FOR OFFICE USE ONLY FOR OFFICE USE ONLY FOR OFFICE USE ONLY

{ } CONSENT FORM received and reviewed by ____

{ } CONSENT FORM placed in the patient's medical record on _______________________________

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
{ } Communication barriers prohibited obtaining the acknowledgement
{ } An emergency situation prevented us from obtaining acknowledgement
{ } Other (please specify) ____
____

Form Printed 1/21/16