PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that my written permission is necessary for protected health information to be released to anyone including family or friends who may be involved in my treatment or care except as permitted or required by law.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient's Printed Name _____Patient's Birthdate _____

Patient/Parent/Guardian Signature _____

Date _____

Please see the front desk to review a copy of our Privacy Practices.
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I HEREBY GIVE PERMISSION FOR MEDICAL INFORMATION TO BE LEFT ON MY VOICE MAIL/ANSWERING MACHINE AT THE FOLLOWING NUMBER (S):

_____ _____ _____
HOME # WORK # CELL #

I HEREBY GIVE PERMISSION FOR THE FOLLOWING NAMED PERSON (S) TO RECEIVE MEDICAL INFORMATION ON MY BEHALF:

_____ _____
NAME RELATIONSHIP

_____ _____
NAME RELATIONSHIP

FEDERAL GOVERNMENT DISCLOSURE

We are required by the federal government to report on specific demographic information of our patient base. You are not required to answer the following:

ETHNICITY

- ☐ Hispanic/ Latino
- ☐ Not Hispanic/ Latino
- ☐ Prefer not to answer

RACE

- ☐ American Indian
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ White
- ☐ Other
- ☐ Prefer not to answer