Privacy Acknowledgement Form

Our notice of Privacy practices provides information about how we may use and release protected health information about you. You have the right to review our Notice. If we change our notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk. You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or healthcare operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice. By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

Patient Name: _________________________________ **DOB:**_________________

Signature: _________________________________**Date:** ______________________

I acknowledge and agree that the practice may disclose my protected health information and medical record information to the following individuals who are either my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf: ***(If none, please write none and initial).***

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