PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

By signing below, I acknowledge that I have received a copy of my provider's Notice of Privacy Practices, containing information about how my protected health information may be used and/or disclosed.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

Patient Name_____

If Patient is under 18, name of Parent/Legal Guardian_____

Signature_____

Relationship to Patient_____

*By signing this form, you are certifying that you have legal authority to make healthcare decisions about the minor patient listed above

NOTICE REGARDING OTHER INDIVIDUALS INVOLVED IN THE PATIENT'S CARE

As the Personal Representative of the above-named patient, I am identifying the following individual(s) who may accompany the above-named patient to clinic visits, who are involved in the patient's care and treatment and who may receive information regarding the individual's involvement in the patient's care and treatment.

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY CHILD'S APPOINTMENTS, TREATMENT & BILLING INFORMATION AND OFFICE NOTIFICATIONS (UNEXPECTED OFFICE CLOSURES, SPECIAL OFFICE PROMOTIONS) VIA:

☐ Cell Phone Confirmation/Text Message_____
☐ Home Phone Confirmation ☐ Email Confirmation_____
☐ Any of the Above

I AUTHORIZE INFORMATION ABOUT MY CHILD'S HEALTH BE CONVEYED VIA:

☐ Cell Phone Confirmation/Text Message_____
☐Home Phone Confirmation ☐ Email Confirmation_____
☐ Any of the Above