Patient Name:_____

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, _____have received, or have been offered and refused, a copy of this office's Notice of Privacy Practices.

_____ _____

Patient Name (Printed) Signature

_____

Date

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself or your child covered under the Privacy Act to people other than yourself, and approve voice mail/text messages.

I,_____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself or my child. This includes appointment and financial information unless otherwise specified:

_____ _____

Name (printed) Relationship

_____ _____

Name (printed) Relationship

I also authorize voice mail messages (or texts) to be left on the following number:_____.

Sigature_____Date_____

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

___Communications barriers prohibited obtaining the acknowledgement

___An emergency situation prevented us from obtaining acknowledgement

___ Other (please specify)

_____

_____