



HIPAA
PATIENT ACKNOWLEDGEMENT of
RECEIPT OF NOTICE - HIPAA PRIVACY PRACTICES ACT
CONSENT and AUTHORIZATION FORM
RELEASE OF INFORMATION FORM

Patient Name (print): _____ **Date:** _____

The undersigned acknowledges receipt of a copy of this healthcare facility's currently effective Notice of Privacy Practices. A copy of this document shall be as effective as the original and is available by request.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, DISCUSS TREATMENT, HEALTH and/or BILLING INFORMATION VIA:

_____ Home Phone _____ Cell Phone _____ Work Phone

_____ Text Message _____ Email

MY SIGNATURE WILL ALSO SERVE AS A RECORDS RELEASE AS NEEDED.

* _____
Patient or parent/guardian/legal rep. *signature** **Print name of parent/guardian/legal rep.**

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