ACNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I, ____ have had full opportunity to read, understand the contents, and I have received a copy of this office's Notice of Privacy Practices. I understand that by signing this form, I am giving my consent for use and disclosure of my protected health information, x-rays, and/or photos to carry out all payment activities and health care operations.

Signature ____ Date _____________________________

If this form is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name_________________________________ Date________________________

Relationship to Patient____

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) ____

AUTHORIZATION FOR FAMILY COMMUNICATION

I authorize the office to release the following information about my health care (please check all that apply):

- □ Any and all information
- □ Information necessary to schedule, confirm, cancel, or reschedule appointments
- □ Information about prescriptions
- □ Information about my bills or account
- □ I grant permission to this individual to bring my child to his/her appointments

This authorization applies to the following individual(s)

Name:	Relationship to the Patient:
____	__________________________________
____	__________________________________

- □ I choose not to authorize any individuals at this time

I understand that this authorization is valid until revoked by the patient, or the patient's parent/guardian.

Signature ____ Date _______________________________

Printed Name ____