

Medical Record Number _____

ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of my physician's Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by this practice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians, and staff.

Signature of Patient or Patient's Personal Representative

Print Name of Patient or Patient's Personal Representative

Description of Personal Representative's Authority

Date

If you have any questions about this notice or would like further information, please contact the office manager.

<p>For Office Use Only: If the patient does not sign this acknowledgement and consent form, record here the good faith efforts made to obtain this acknowledgement and consent.</p> <p>_____</p> <p>_____</p> <p>_____</p>
