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.
I have received a copy of this office's Notice of Privacy Practices.
Signature: _____ Date: _____

Authorization to Disclose Health Information

I direct my health care and medical services providers and payers to disclose and release my protected health information described below to:
***Name**: (WHO CAN CONFIRM APPOINTMENT OR ANSWER BILLING QUESTIONS) **Relationship**:*
_____ _____
_____ _____
_____ _____
_____ _____
Health Information to be disclosed upon the request of the person named above --
(**Check either A or B**):
___A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
___B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
___Mental health records
___Communicable diseases (including HIV and AIDS)
___Alcohol/drug abuse treatment
___Other (please specify): _____
Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):
An electronic record or access through an online portal or a Hard copy

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____
If unable to reach me:
[ ] you may leave a detailed message (voice and/or text)
[ ] please leave a message asking me to return your call
[ ] Information is not to be released to anyone.
[ ] _____
The best time to reach me is (day) _____ between (time)_____

This Authorization will remain in effect until terminated by me in writing or until five years from today's date, or unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

I understand that I have the right to revoke this Authorization, in writing, at any time by notifying this office. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by this rule. I understand that my health care provider cannot condition treatment on whether I sign this Authorization.
* You May Refuse to Sign This Acknowledgement*

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)_____

Staff Initials: ____ Date: _____