I have received a copy of this office's Notice of Privacy Practices.
(You May Refuse to Sign This Acknowledgment)

Patient Name: _____

Parent/Guardian Name(if applicable): _____

Signature: _____ 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)

Authorization for Release of Health Information

Patient Name: _____ DOB:_____

The person named above hereby authorizes protected medical information to be requested by and/or released to the following individual(s):

1._____ Realationship to Patient:_____

2._____ Realationship to Patient:_____

☐ I do not authorize my protected health information to be requested or released by any individual

I understand I may notify the doctors office at any time of changes to this form, which would require a new form and authorization to be completed.

Signature_____ Date: _____