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PHYSICIANS
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Acknowledgement of Receipt of Privacy Practices and Consent for Use and Disclosure of Health Information

The Notice describes in more detail how your health information may be used and disclosed and how a patient may access his or her information. Patients have the right to read our Notice of Privacy Practices before deciding whether to sign this consent. A copy of the Notice is available upon request. The Notice provides a description of the uses and disclosures of a patient's protected health information for treatment, payment activities and healthcare operations.

Purpose of Consent: By signing this form, patients consent to the use and disclosure of his or her protected health information to carry out treatment, payment activities and healthcare operations.

Agreement: I have had the opportunity to request a copy of the Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

By signing below, I acknowledge the Notice of Privacy Practices.

_____
Patient Name (Print)

_____ _____
Patient 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
- ☐ Other (please specify) _____