Privacy Practices Acknowledgement Form

I have received the Notice of Privacy Practices and have been provided an opportunity to review and understand it.

Name of Patient: ______________________________________

Date of Birth: ____

Release of Medical Information

Please allow the following persons to obtain any medical information on my behalf from the office or the physician. Please keep in mind, these are the only people we will be able to communicate with regarding test results and insurance information.

Name: ______________________________ Relationship: ___________
Name: ______________________________ Relationship: ___________
Name: ______________________________ Relationship: ___________

Signature of Patient: __________________________ Date: __________