

# Acknowledgment of Receipt NOTICE OF PRIVACY PRACTICES

Your signature acknowledges that you have received a copy of the Notice of Privacy Practices.

Patient Name \_\_\_\_\_

Signature of Patient \_\_\_\_\_

Date Signed \_\_\_\_\_

Patient Representative (if applicable) \_\_\_\_\_

Relationship of Representative \_\_\_\_\_

## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This authorization will allow Entity to disclose protected health information to the specific person, company, or agency listed below.

I, \_\_\_\_\_  
NAME OF PATIENT

hereby authorize \_\_\_\_\_  
NAME OF ENTITY

to release \_\_\_\_\_  
INFORMATION TO BE DISCLOSED

To \_\_\_\_\_  
NAME OF PERSON OR COMPANY AUTHORIZED TO MAKE USE OR DISCLOSURE

\_\_\_\_\_  
EXPIRATION DATE OR EXPIRATION EVENT

### IMPORTANT INFORMATION FOR THE PATIENT MAKING THIS AUTHORIZATION

- You have the right to withdraw (revoke) this authorization at any time except to the extent that action has been taken in reliance on this authorization.
- To withdraw or revoke this authorization, please provide your request in writing to the Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal privacy law.
- You have the right to inspect or copy the information that is to be disclosed in accordance with this authorization.
- You have the right to receive a copy of this signed authorization.
- You have the right to refuse to sign this authorization and Entity will not condition the provision of treatment on your authorization to disclose this information.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF AUTHORIZED REPRESENTATIVE

\_\_\_\_\_  
RELATIONSHIP