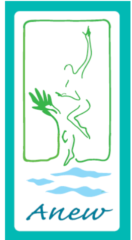

HIPAA Privacy Policy-Acknowledgment

We keep a record of the health care services we provide you. You may ask to see and copy these records. You may also ask to have these records corrected. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about them by contacting the Medical Records/Privacy Officer or Office Manager.

- ☐ Patient agrees to release of medical or other information to process claim.
- ☐ Patient agrees to accept assignment of payment
- ☐ Patient gave office the permission to leave a message on their answering machine
- ☐ Patient gave permission to discuss their medical condition with another person

By my signature below, I acknowledge that I am aware of the Notice of Privacy Practices and authorize the above mentioned release of information.

____ ________________________

(**Patient or legally authorized individual signature)** **(Date)**

____ ________________________

(Printed name if signed on behalf of patient) (Relationship)

This form will be retained in your medical file

Update________________ Update________________ Update____________

Revised 1.14.14