PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date:			
HOW DO YOU WANT TO BE	ADDRESSED WHEN SUM	MONED FROM THE RECEPTION AREA?	
First name only	☐ Proper Surname only	y	
		CCESS TO YOUR HEALTH INFORMATION: retakers who can have access to this	
Name:	Relations	ship:	
Name:	Relations	Relationship:	
I AUTHORIZE CONTACT FRO AND BILLING INFORMATION Cell phone Confirma Home Phone Confirm Work Phone Confirm	N VIA: ation	RM MY APPOINTMENTS, TREATMENT, Text message to my Cell Phone E-mail Confirmation Any of the Above	
Privacy Practices for this he effective as the original. MY	althcare facility. A copy of SIGNATURE WILL ALSO S RELEASE SHOULD I REQU	desired, of the currently effective Notice of this signed, dated document shall be as SERVE AS A PROTECTED HEALTH JEST TREATMENT OR RADIOGRAPHS BE THE FUTURE.	
Please <u>print</u> your name	P	Please <u>sign</u> your name	
Legal Representative	D	Description of Authority	
Your comments regarding A	Acknowledgements of Con	nsents:	