



Patient Name: \_\_\_\_\_ Acct: \_\_\_\_\_

### NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

I, the undersigned, acknowledge receipt of the Notice of Privacy Practices.

**X** \_\_\_\_\_ / \_\_\_\_\_  
(Signature, patient or personal representative) (Date)

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient.

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### PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

**X** \_\_\_\_\_  
Signature (Parent/Guardian Signature if Signing for a Minor) Date

**TO BE FILED AND RETAINED FOR A MINIMUM OF SIX (6) YEARS.**