

Marilyn M. Jackson, MD, MPH PLLC

ACKNOWLEDGEMENT AND CONSENT

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES
AND
CONSENT TO USE PROTECTED HEALTH INFORMATION FOR
TREATMENT, PAYMENT AND OPERATIONS

By signing below, I acknowledge that a copy of the Notice of Privacy Practices has been made available to me and I have been provided an opportunity to review it. I have been advised of how my health information may be used and disclosed by the office listed at the beginning of the notice, and how I may obtain access to and control of this information. By signing below, I consent to the use and disclosure of my health information:

- To treat me and arrange for my medical care*
- To seek and receive payment for services given to me*
- For the business operations of the office, it's staff and facilities listed at the beginning of the notice*

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

Witness