## NOTICE OF PRIVACY PRACTICES – RECEIPT AND ACKNOWLEDGMENT

**I acknowledge by my signature set out below that my health care provider has provided to me, and I have received a Notice of Privacy Practices, which bears as a header or otherwise prominently displayed, the following:**

**"THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."**

**I also hereby authorize my Health Care Provider and PCA to release and communicate my Protected Health Information to the persons identified as follows (specifically individuals other than patient inquiring about billing information):**

| Name | Address | Telephone |
|---|---|---|
| **Date of Birth** | **Social Security Number** | **Place of Birth** |

| Name | Address | Telephone |
|---|---|---|
| **Date of Birth** | **Social Security Number** | **Place of Birth** |

**I have been provided and have taken advantage of the opportunity to review the Notice of Privacy Practices.**

**NAME: _____**

**SIGNATURE: _____**

**DATE OF BIRTH: _____**

**DATE: _____**

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