Garner, Cuervo and Associates
6130 Oxon Hill road, Suite 203
Oxon Hill, Maryland 20745
301-839-4200

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Garner, Cuervo and Associates. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Garner, Cuervo and Associates reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information as indicated below. *				
ANY MEMBER OF MY IMMEDIATE FAMILY	☐	YES	☐	NO
SPOUSE ONLY	☐	YES	☐	NO
TELEPHONE MESSAGES	☐	YES	☐	NO
RECALL POST CARDS	☐	YES	☐	NO
OFFICE CO-WORKER	☐	YES	☐	NO
FRIEND OR ASSOCIATE (Specify)	☐	YES	☐	NO
OTHER: (Specify)	☐	YES	☐	NO

*Failure to check any individual box does not constitute permission, consent, or authorization to disclose my personal health information. Each item of authorization must be signed or otherwise acknowledged.

_____ _____

Name of Patient or Personal Representative **Signature of Patient** or Personal Representative

_____ _____

Date Description of Personal Representative's Authority