ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with the Notice of Privacy Practices (Notice);

- The Notice tells me how Morgan Family Medicine PLLC (The Practice) will use protected health information for the purposes of treatment, payment for treatment, and health care operations
- The Notice explains in more detail how the Practice may use and share protected health information for other than treatment, payment, and health care operations.
- The Practice will also use and share protected health information as permitted or required by law.
- If I am a patient receiving health services at the Practice, I consent to the Practice using and disclosing my protected health information contained in my treatment records by the Practice for the purposes detailed in the Practice's Notice or Privacy Practices.
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Patient's Name (print)____

Patient's Date of Birth ____

This form must be signed by either the patient or by the patient's personal representative.
If this form is signed by the patient's personal representative, please provide a copy of the document naming the personal representative and provide a description of the personal representative's authority to act on behalf of the patient: ____

____

____

____ ________________________
Signature of Patient or Patient's Personal Representative Date

Current Contact Information for Patient or Personal Representative signing this form

Name (print)____

Address ____

Telephone Number ____

<u>FOR PRACTICE USE ONLY</u>

I attempted to obtain the signature of the patient or representative but did not because:

_____ It was emergency treatment

_____ I could not communicate with the patient

_____ The patient refused to sign

_____ The patient was unable to sign because ____

Staff signature____ Date______________________