PATIENT ACKNOWLEDGMENT FORM

Patient Acknowledgment of Receipt of Piedmont HealthCare's Privacy Practices

Acct #: _____

Patient Name: _____ Date of Birth: _____

My signature below acknowledges that I was offered a copy of the Notice of Privacy Practices of Piedmont HealthCare (H.I.P.A.A.)

X_____ Today's Date:_____

Patient or Legally authorized individual signature

_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representive, etc.)

This section must be completed if you wish this office to release information concerning your care to a family member.

*THIS RELEASE APPLIES **ONLY** TO THIS PIEDMONT HEALTHCARE SITE*

In the event that you are not available to receive personal information, such as lab results, billing information, and/or medications, your consent is required in order for another person to obtain this information.

I authorize Advanced Healthcare and/or their staff to leave medical information to the following people: Please list names of authorized people and relation to patient.

This information can be released verbally, by telephone message, written or faxed.

Name	Relation to Patient

☐ ***PLEASE MARK AN "X" IN THIS BOX IF IT IS OK TO LEAVE A MESSAGE ON YOUR HOME OR CELL PHONE. IF THIS BOX ISN'T MARKED A BASIC (NON-INFORMATIONAL)MESSAGE WILL BE LEFT.***