Piedmont HealthCare

PATIENT ACKNOWLEDGMENT FORM

Patient Acknowledgment of Receipt of Piedmont HealthCare's Privacy Practices

Patient Name:_____ Date of Birth:_____
Chart Number: _____ Account Number: _____
(optional)
Physician: Dr. Kush Patel

My signature below indicates that I have received a copy of Piedmont HealthCare's "Patient Privacy Rights Notice".

_____ _____ _____
Patient or legally authorized individual signature Date Time

Relationship to patient (*if signed by anyone other than the patient; parent, legal guardian, personal representative, 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*

I authorize Physician: **Dr. Kush Patel** to release information concerning my treatment to:

_____ _____
Name Date

_____ _____
Name Date

_____ _____
Name Date

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

☐ Patient has "Restrictive Information" form on file