Lake Norman Neurology
Piedmont HealthCare

PATIENT ACKNOWLEDGMENT FORM

Patient Name:_____ Date of Birth:_____

Do you want to give authorization for other family members to have access to your medical information?

_____ Yes, I do want to give authorization to the following individual.

NAME: RELATIONSHIP: PHONE:

1._____

2._____

3._____

_____ Yes, I give permission to leave information on my answering machine.

Phone Number: _____

_____ No, I do not want to give anyone authorization to have access to my medical information.

Signature _____

Date: _____

PATIENT ACKNOWLEDGMENT OF RECEIPT OF PIEDMONT HEALTHCARE'S PRIVACY PRACTICES

My signature below indicates that I have received a copy of PHC "Patient Privacy Rights Notice"

Patient or legally authorized individual signature:_____ Date:_____

Relationship to patient:_____