PATIENT ACKNOWLEDGMENT FORM

Patient Acknowledgment of Receipt of Piedmont HealthCare's Privacy Practices

Patient Name**:** _____ Date of Birth: _____

Physician: _____

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**

Due to strict HIPAA guidelines, we cannot release medical information to anyone but the patient unless otherwise authorized. Please choose **one** of the following options.

Option 1: If you wish for any family member/friend to have access to your medical records, please provide his/her information, sign and date below.

Individual:	**Relationship:**	**Phone Number:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

Patient Signature **Date**

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Option 2: I do not authorize any individual(s) to have access to my medical information.

_____ _____

Patient Signature **Date**

Please mark which type of information we may leave as a message on the following

PREFERRED PHONE NUMBER: _____

☐ All/Any Information ☐ Prescription/Medication Info

☐ Appointment Times ☐ Test Results

☐ Do Not Leave Message