



PATIENT ACKNOWLEDGMENT FORM

Patient Acknowledgment of Receipt of Piedmont HealthCare’s Privacy Practices

Patient Name: _____ Date of Birth: _____

Chart Number: _____ Account Number: _____
(optional)

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

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: _____ 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