PATIENT ACKNOWLEDGMENT FORM

Receipt of Piedmont HealthCare's Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

My signature below indicates that I have been offered and understand I have a right to receive a copy of Piedmont HealthCare's "Notice of Privacy Practices".

_____ _____ _____

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 PIEDMONT HEALTHCARE TO RELEASE YOUR PROTECTED HEALTH INFORMATION TO A FAMILY MEMBER OR PERSONAL REPRESENTATIVE.

THIS RELEASE APPLIES TO *ALL* PIEDMONT HEALTHCARE LOCATIONS

I authorize Piedmont HealthCare to release my Protected Health Information to the following individual(s):

_____	_____	_____
Name	Relationship	Telephone #
_____	_____	_____
Name	Relationship	Telephone #
_____	_____	_____
Name	Relationship	Telephone #

_____ _____

Patient or legally authorized individual signature Date