Lifetime Notice of Acknowledgement

Acknowledgment:

I, ____________________________________ acknowledge that I have received the following information:

__________ Notice of Privacy Practices
(Initials)

__________ Patient's Bill of Rights and Responsibilities
(Initials)

__________ Identity Theft Protection Program
(Initials)

__________ After hours Contact Information
(Initials)

__________ I designate the following person(s) to which my PHI (Protected Health Information) may be disclosed:
(Initials)

____
Name of Designee

____
Name of Designee

____
Name of Designee

____ ______________________
Patient or Personal Representative – Printed Name Date

____ ______________________
Signature of Patient or Personal Representative Relationship to Patient

Patient Name: ____________________________________

D.O.B. ____________________ Pt. No. __________________