Acknowledgement of Receipt

Acknowledgement Of Receipt Of Our "Notice Of Privacy Practices"

Notice of Privacy Practices: Law requires us to make a good faith effort to obtain your signature signifying you have been provided a copy of our Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of our treatment, payment, health care operations, and the uses and disclosures we may make of your protected health information. It explains in detail the procedures we use to protect your health care and personal information. A full copy of our Notice of Privacy Practices accompanies this Consent. Please take the time to read it carefully and completely.

We reserve the right to revise our Privacy Practices at any time. If changes are made we will issue a revised copy of our Privacy Practices. These changes apply to any of your protected health information that we maintain.

I, ____, have reviewed a copy of this office's Notice of Privacy Practices.

Consent For Use And Disclosure Of Health Information

Purpose of Consent: By signing this form, you will consent to the use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations by Dr. Mathew B. Dorsch and staff.

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation to our HIPAA compliance officer. Please understand that revocation of this Consent will NOT affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, ____, have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: ______________________________ Date: ______________

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ❏ Individual refused to sign
- ❏ Communication barriers prohibited obtaining acknowledgement

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