

Acknowledgement of Receipt of "NOTICE OF PRIVACY PRACTICES" for Protected Health Information

Today I, _____ received a copy of the "Notice of Privacy Practices".
(Patient's Name or Representative)

*If you have not received a copy of the "Notice of Privacy Practices" please obtain one from the receptionist.

FOR USE BY OFFICE PERSONAL ONLY (Complete if patient Acknowledgement is not obtained)

An Acknowledgement of Receipt of notice of Privacy Practices was not obtained because:

- o Patient refused to sign Acknowledgement.
- o Unable to gain signed Acknowledgement due to communication/language or other barrier.
- o Patient unable to sign Acknowledgement due to emergency treatment situation.
- o Other: Please indicate reason, _____

Signature of Representative: _____

Date: _____

Authorization for Disclosure of Protected Health Information

I authorize the Use/ Disclosure of Health Information about me as described below.

Advanced Surgical Group of N.W. GA, **p.e.** may release my health information or discuss my treatment with the following persons; please list anyone we may speak with (e.g. spouse, friends, family, etc ...)

OR

If you **DO NOT** want your health information released to anyone or for our office to speak to anyone other than yourself, please initial here.

Advanced Surgical Group of N.W. GA, **p.e.** may leave a message with Medical and/or Test Results at the following number:

Phone Number Here!

Patient Signature

Date