Park Allergy Center, PC
Form Number HF001a

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices.

_____
Name of patient

_____
Signature of patient or personal representative

_____
If signed by personal representative, relationship to patient

_____
Date

I further authorize the following person(s) to make the request for the use or disclosure of my Medical Information (PHI) on my behalf:

□ Myself □ Spouse:_____ □ Parent(s):_____

□ Child(ren):_____ □ Other:_____

Office Use Only:

Our practice will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If written acknowledgement is not obtained, our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

. □ Refused to Sign □ Physically unable to sign
(Other)_____
_____
_____

Employee Signature:_____ Date:_____