# HIPAA

## ACKNOWLEDGEMENT

**This is to certify that I, the undersigned hereby consent to and authorize the disclosure of any medical information to the following:**

☐HUSBAND ☐WIFE ☐CHILD ☐PARENT

☐OTHER, PLEASE SPECIFY:________________________________________

**May we leave a message at the contact number you provided?** ☐**Yes** ☐**No**

**May you be called at your place of employment to be informed of your medical information?** ☐**Yes** ☐**No**

**If you *do not want* a certain disclosure made to the above, it is *your responsibility* to *notify us*.**

**Thank you for your cooperation.**

**I HEREBY ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.**

| **Witness:** | **Patient:** |
|---|---|
| ______________________________ | ______________________________ |
| *Witness Signature* | *Patient Signature* |
| ______________________________ | ______________________________ |
| *Date* | *Print Name* |