PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

THE UNDERSIGNED ACKNOWLEDGES REVIEW OF A COPY OF THE CURRENTLY EFFECTIVE NOTICE OF PRIVACY PRACTICES FOR THIS HEALTHCARE FACILITY. A COPY OF THIS SIGNED, DATED DOCUMENT SHALL BE AS EFFECTIVE AS THE ORIGINAL.

PRIMARY CARE ASSOCIATES OF HAGERSTOWN, LLC

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

SIGNATURE: _____

EMAIL: _____

PLEASE LIST ANY PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

NAME: _____ RELATIONSHIP/PHONE: _____

NAME: _____ RELATIONSHIP/PHONE: _____

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

_____ CELL PHONE

_____ HOME PHONE

_____ WORK PHONE

_____ MESSAGES WITH FAMILY MEMBERS

_____ MESSAGES ON MACHINE

_____ ANY OF THE ABOVE

IN SIGNING THIS HIPAA PATIENT ACKNOWLEDGEMENT FORM, YOU ACKNOWLEDGE AND AUTHORIZE THAT THIS OFFICE MAY RECOMMEND PRODUCTS OR SERVICES TO PROMOTE YOUR IMPROVED HEALTH. THE OFFICE MAY OR MAY NOT RECEIVE THIRD PARTY REMUNERATION FROM THESE AFFLIATED COMPANIES. WE, UNDER CURRENT HIPAA OMNIBUS RULE, PROVIDE YOU THIS INFORMATION WITH YOUR KNOWLEDGE AND CONSENT.