Patient's Acknowledgement of Review of Notice of Privacy Practices

I, _____, have had the opportunity to review and consider the *Notice of Privacy Practices* .
(Please print - Patient or Parent if Patient is under 18 yrs. Of age)

Understand that by signing this form, you will consent to the use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. I am entitled to a copy of this consent after I sign it and will request if desired.

Please Print Patient's Name: _____

Please Date and Sign: _____

Relationship to Patient: _____

Revocation of consent – Don't sign this part if you signed above.
I revoke my Consent for the use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. **I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.**

Please print patient's name: _____

Please print responsible party name: _____

Relationship to patient: _____

Please sign and date: _____
(Patient or parent if patient is under 18 yrs. Of age) (Date)

OFFICE USE:
The office was unable to obtain a signed Acknowledgement from the above patient/parent for the following reasons: