

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Life Care Family Practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

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Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignments. Regulations pertaining to medical assignment of benefits apply.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

*If not signed by patient, please indicate relationship to patient*

Relationship: \_\_\_\_\_

Witnessed by: \_\_\_\_\_

IF PATIENT REFUSES TO SIGN, INDICATE YOUR ATTEMPT TO OBTAIN A SIGNATURE BELOW.

- Patient refused to sign this Acknowledgement.

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Employee Name: \_\_\_\_\_