W & R Geyser Rd LLC

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

***** You may refuse to sign this authorization. In refusing we may not be allowed to process your insurance claims.

Date:_____

The undersigned acknowledges receipt 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. MY SIGNATURE WILL ALSO SERVE AS A DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS TO BE SENT TO ANOTHER ATTENDING DOCTOR/FACILITY IN THE FUTURE.

_____

Please PRINT name above

_____

Please SIGN name above

PLEASE LIST ANY OTHER PARTIES WHO YOU CONSENT TO HAVING ACCESS TO YOUR HEALTH INFORMATION:

NAME: _____ RELATIONSHIP:_____

NAME: _____ RELATIONSHIP:_____

FOR OFFICE USE ONLY:

I attempted to obtain the patients (or representatives) signature on the acknowledgment but did not because:

____ It was emergency treatment

____ I could not communicate with the patients

____ The patient refused to sign

____ The patient was unable to sign because _____

Signed: _____