Acknowledgement of Receipt of Privacy Practices

I acknowledge that I have received a copy of Healthy Strategies Family Doc, PA Notice of Privacy Practices.

____
Printed Name

____ ____________________
Signature of Patient or Representative Date

____
If Representative, Relationship to Patient

Do we have permission to share protected health information with your:
If yes, please list their name(s) and what information is authorized to share.

Spouse____

Adult Children____

Adult Sibling____

Friend/Personal Representative____

The above authorization(s) may be revoked at any time.

____ ____________________
Signature of Patient or Representative Date

____
If Representative, Relationship to Patient