Acknowledgement of Receipt of Notice of Privacy Practices;

Authorization to for Practice to Utilize Information as Described in Privacy Notice;

Patient's Consent for Practice to Share Protected Health Information with Other Named Parties

Rossmoor Medical Associates

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ parent or guardian of minor patient ☐ guardian or conservator of an incompetent patient

☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

Please indicate by signature below that you are authorizing us to use private patient information as indicated in our notice of Privacy Practices. This is not a change in how we've historically used your information. New laws require us to disclose how we use this information.

Signed: _____ Date: _____

In addition to our normal operational disclosures of privacy information please identify who we may release your healthcare information to. Each name must be identified. These should be people who help you with your healthcare needs and may need to be knowledgeable about your condition, treatment and options. It is still the responsibility of the below named parties to request this information.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Signed: _____ Date: _____

Thank you!