SUBURBAN GERIATRICS
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy practices

x _____
Please print your name here

x _____
Signature

x _____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement or receipt of our Notice of Privacy from this patient, but it could not be obtained because:

☐ The patient refused to sign

☐ Due to an emergency situation it was not possible to obtain acknowledgement

☐ We weren't able to communicate with the patient

☐Other (Please provide specific details)

_____
_____
_____

_____ _____
Employee signature Date

HIPAA Acknowledgement of receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state law.

SUBURBAN GERIATRICS
CONSENT FOR USE/ DISCLOSURE OF HEALTH INFORMATION

Patient's Name:

Patient's Date of Birth: Patient's SSN:

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent for, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices,** we reserve the right to change our privacy practices. If we should do so, we will issue a revised notice. Since revisions may apply to your health care information, you have the right to receive a cop by contacting our Privacy Officer.

You have the right to **revoke** consent by giving written notice to our privacy officer. The revocation will not affect actions that were already taken in reliance upon this consent. You should also understand that if you revoke this consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

_____ _____
Patient's Signature or Signature of Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

Privacy Officer: Colleen Moran RN, Office Manager
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