



PATIENT ACKNOWLEDGMENT FORM

Patient Acknowledgment of Receipt of Piedmont HealthCare’s Privacy Practices

Patient Name: _____

Date of Birth: _____

Physician: _____

My signature below indicates that I have received a copy of Piedmont HealthCare’s “Patient Privacy Rights Notice”.

Patient or legally authorized individual signature

Date

Due to strict HIPAA guidelines, we cannot release medical information to anyone but the patient unless otherwise authorized. Please choose **one** of the following options.

Option 1: If you wish for any family member/friend to have access to your medical records, please provide his/her information, sign and date below.

Individual:

Relationship:

Phone Number:

Patient Signature

Date

Option 2: I do not authorize any individual(s) to have access to my medical information.

Patient Signature

Date

Please mark which type of information we may leave as a message on the following

PREFERRED PHONE NUMBER: _____

All/Any Information

Prescription/Medication Info

Appointment Times

Test Results

Do Not Leave Message