

Receipt of Notice of Privacy Practices – Written Acknowledgement Form

I, _____, have received a copy of HEARTLAND NEUROLOGY ASSOCIATES, P.C.'s Notice of Privacy Practices.

Signature of Patient

Date



PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION TO THOSE INVOLVED IN THE PATIENT'S CARE AND FOR NOTIFICATION PURPOSES

Patient's Name:		
..... Last First Middle Initial
Home Address:		
..... City State Zip Code
Home Telephone:	Date of Birth:	

I, _____, request that Heartland Neurology Associates, P.C. **disclose to the following family members or friends** my protected health information that is directly relevant to such person's involvement with my care or payment related to my care. **Heartland Neurology Associates, P.C. may also use or disclose this information as necessary to notify the following individuals of my general condition, location or death.**

Signature of Patient (or Healthcare Representative)

Date

If patient is unable to sign, but circumstances are such that it can be reasonably inferred that the patient intends to consent to such disclosure, so note by checking and initialing here: _____

