Acknowledgement of Notification of Health Information Privacy Practices

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Privacy Officer: Mark S. Kita, M.D.

I hereby acknowledge that I have been notified of this medical practice's Health Information Privacy Practices, given a copy of the Notice of Health Information Privacy Practices to review if requested and/or have been offered a personal copy of the office's Notice of Health Information Privacy Practices. I further acknowledge that a copy of the current Notice of Health Information Privacy Practices was available in the reception area for my review. Any amended Notice of Health Information Privacy Practices will also be available for my review in the reception area of this medical office.

Additionally, I authorize the release of any of my medical information to the following (write **NONE** if you do not wish to allow the release of your medical information to any other people):

_____

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: _____

Complete the following only if patient refuses to sign the acknowledgement:

Reason for Refusal:_____

_____

_____