

SUMNER MEDICAL GROUP

Notice of Privacy Practice Acknowledgement Form

By my signature below, I am acknowledging I have received a copy of the Sumner Medical Group Notice of Privacy Practices concerning my protected healthcare information.

Patient Name (Print)

Patient's Date of Birth

Patient or Patient's Representative Signature

Date

I authorize the following individuals to receive information about my health status, which may include information about my protected healthcare information.

Print Name

Relationship, Date of Birth

Print Name

Relationship, Date of Birth

Print Name

Relationship, Date of Birth

_____ I CHOOSE NOT TO HAVE ANYONE RECEIVE MY PROTECTED HEALTH-CARE INFORMATION (PHI). I understand that there are three expectations to releasing PHI, that do not require my approval, those being TREATMENT, PAYMENT and HEALTHCARE OPERATIONS.

I understand Sumner Medical Group will only release my protected healthcare information to the individuals that I have indicated on this form. All other requests for protected healthcare information must be made in accordance with the Sumner Medical Group Notice of Privacy Practices.

Patient's Name (Print)

Date

Patient or Patient's Representative Signature
