ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES/HIPPA

I, _____ have received a copy of Basin Podiatry, P.A. Notice of Privacy Practices.

_____

Signature of Patient/Legal Guardian Date

Staff to Fill Out this Section if Patient's Signature Not Obtained

Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reasons:

_____ Patient refused to sign

_____ Emergency situation kept us from obtaining the patient's signature.

_____ Patient gave verbal consent _____(witness)

_____ Other_____

I hereby authorize Basin Podiatry, P.A., to release healthcare information on my behalf to the person(s) listed below (ex: Family member, friend, etc.)

Name: _____ DOB: _____

Address: _____

City: _____ State _____ Zip Code _____

Phone: _____ Relationship: _____

This request and authorization applies to:

- Healthcare Information relating to the following treatment, condition, or dates:

_____

- All healthcare information

Patient Signature: _____ Date:_____

Witness Signature: _____ Date: _____

This authorization expires yearly and will be obtained at the beginning of every year, thank you for your cooperation and God Bless!