Paragon Health, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of Notice of Privacy Practices.

Name of Patient ______________________________

Signature of Patient ______________________________ Date ____/____/____

If signed by personal representative, Relationship to Patient ______________________________

I further authorize the following person(s) to make the request for the use or disclosure of my Medical Information (PHI) on my behalf:

☐ Myself ☐ Spouse: ______________ ☐ Parent(s) ______________

☐ Child(ren): ______________ ☐ Other: ______________

OFFICE USE ONLY

Our practice will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If written acknowledgement is not obtained, our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgment was not obtained.

☐ Refused to sign ☐ Physically unable to sign

☐ Other: ______________________________

Employees Signature ______________ Division ______________ Date ____/____/____

11/13 POP-3747