

# North Florida Acupuncture

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

I would like to receive telephone communication or messages via:  
(Check all that apply)

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Pager: \_\_\_\_\_

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\_\_\_\_\_  
Please print name above

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\_\_\_\_\_  
Please sign name (signature) above

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Date

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### FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our notice of Privacy Practices, but the acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

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# North Florida Acupuncture

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## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices at any time.

You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action that we took in reliance on this consent before we received your revocation, and we may decline to treat you or to continue treating you if you revoke this consent.

I authorize you to disclose health information to (leave message with, pick-up herbs etc.):

No person at this time.

Spouse: \_\_\_\_\_

Family member: \_\_\_\_\_

Friend: \_\_\_\_\_

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

### REVOCACTION OF CONSENT

I revoke my consent for your use and disclosure of my protected health information, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect action you took in reliance on my consent before you received this written notice of revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_