

## Patient Acknowledgement and Consent Form

You have the right to read our Notice of Privacy Practices before you sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing the Consent.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

**X** \_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

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 health care operations.

**X** \_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

### Revocation of Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will **not** affect any 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.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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### FOR OFFICE USE ONLY

Patient Refused to Sign Because:

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\_\_\_\_\_  
Office Personnel (signature)  
Date: \_\_\_\_\_

\_\_\_\_\_  
Office Personnel (print name)