Peace Valley Internal Medicine, P.C.

Acknowledgement of Receipt of Notice of Privacy Practices
&
Consent for Use and Disclosure of Protected Health Information

I hereby acknowledge that I have received the Office's Notice of Privacy Practices (Revised May, 2019) and consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice.

Name of Patient **(Please Print)** | Date of Birth | Date

Signature of Patient
(or Patient's Personal Representative, if ***applicable)***

Please Print Name of Personal Representative
(if above signed by Personal Representative)

Relationship to Patient

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT, BILLING INFORMATION & OTHER HEALTH INFORMATION ABOUT MYSELF VIA*:*

_____Cell Phone Can we leave a voicemail? **Yes** or **No** Cell Number_____

_____Home Phone Can we leave a voicemail? **Yes** or **No** Home Number_____

_____Work Phone Can we leave a voicemail? **Yes** or **No** Work Number_____

_____Email Can we leave a message? **Yes** or **No** Email_____

_____All of the Above

****

I hereby consent and agree that Peace Valley Internal Medicine, P.C. may disclose information regarding my health information, including information regarding my appointments (date, time), prescription information or other requested health information to the following family members or other specified individuals listed below.
(This includes: spouse, children, parents, grandparents, any care takers who can have access to this patient's records):

Please **PRINT** individuals' names, their relationship to you and their phone number:

Name:_____ Relationship and Phone # :_____

Name:_____ Relationship and Phone # :_____

Name:_____ Relationship and Phone # :_____