( ) New Patient ( ) Established Patient

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have been presented with a copy of Delta Clinic's Notice of Privacy Practices for Protected Health Information, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Please print patient's name:_____ Date of Birth:_____

Signature:_____ Date:_____

If not signed by a patient, please indicate relationship to patient (e.g. spouse).

Relationship:_____ Witnessed by: _____

_____

OFFICE USE ONLY:

Patient or patient's representative refuses to sign acknowledgement or receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____