ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO RELEASE MEDICAL RECORDS

I acknowledge that a copy of the NOTICE OF PRIVACY PRACTICES for Ahwatukee Family Medical Center have been made available to me.

Please list the names and phone number of the individuals involved in your care or with whom you will allow us to share your health and treatment information.

Name:_____ (____)_____

_____ Relationship

Name:_____ (____)_____

_____ Relationship

Name:_____ (____)_____

_____ Relationship

Patient Name:_____ Date of Birth:_____

Signature:_____ Date signed: _____

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my providers participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

Signature:_____ Date:_____