

RADNOR FAMILY PRACTICE

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ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES

I, _____, acknowledge that I have been notified of this practice's privacy policy that includes medical and prescription history, and a written copy of this policy has been made available to me.

Signed

Date

CONSENT TO RELEASE MEDICAL INFORMATION

I, hereby authorize the disclosure of my protected health information (including but not limited to results, prescriptions, and appointment) to the person(s) listed below.

Name: _____ relationship _____

Name: _____ relationship _____

Name: _____ relationship _____

I, hereby authorize the practice to leave health information and appointment reminders on my

Home answering machine # _____

Cell answering machine # _____

Fax # _____