

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

## HEALTH ASSOCIATES MEDICAL GROUP

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of **Health Associates Medical Group's** "NOTICE OF PRIVACY PRACTICES," revision date 07/25/2017.

As required by the Privacy Regulations, Health Associates Medical Group has provided the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that **HEALTH ASSOCIATES MEDICAL GROUP** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

### Requests:

I wish to file a "Request for Restriction" of my Protected Health Information

I wish to object to the following in the "Notice of Privacy Practices"

\_\_\_\_\_

I give permission to Health Associates to discuss my case and any test results with the following persons:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

By way of my signature , I provide Health Associates Medical Group with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

**I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name