

**BEAVER / MILFORD / PAROWAN MEDICAL CLINICS  
CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION**

I, \_\_\_\_\_ HEREBY AUTHORIZE BEAVER / MILFORD / PAROWAN MEDICAL  
(PATIENT AND OR LEGAL GUARDIAN)

CLINICS TO RELEASE MY MEDICAL INFORMATION TO THE FOLLOWING PEOPLE: PERSONALLY,  
BY PHONE, OR BY MESSAGE.

Relatives or personal contacts (please print clearly):

NAME	RELATIONSHIP	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____

SIGNATURE: \_\_\_\_\_  
This authorization will remain valid until I inform the clinics of changes in writing and signed by me.

**BEAVER / MILFORD / PAROWAN MEDICAL CLINICS  
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, \_\_\_\_\_ have received a copy of this office's Notice of Privacy Practices.  
(Please Print)

\_\_\_\_\_  
SIGNATURE:

\_\_\_\_\_  
DATE:

FOR OFFICE USE ONLY

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICE, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

- \_\_\_\_\_ INDIVIDUAL REFUSED TO SIGN
- \_\_\_\_\_ COMMUNICATIONS BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT
- \_\_\_\_\_ AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT
- \_\_\_\_\_ OTHER (Please Specify) \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_