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) ______________________________