Family Health Center of Mission
Acknowledgment of Receiving
Notice of Privacy Practices

I have read, understand, and agree to the terms & conditions in FHCM's Notice of Privacy Practices. By signing this acknowledgment, I consent to the use and disclosure of my protected health information for the purpose of treatment, payment and health care operations. I also give permission for appointment/results reminders to be left on phone number(s) listed in my FHCM patient record.

______________________________________ ________________________

Full Legal Name **Date of Birth**

______________________________________ ________________________

Signature of Patient **Today's Date**

Complete the following only if authorized to sign for another patient, i.e. minor child, determined incompetent or legal custody:

_____________________________________ ________________________

Name of Personal Representative ***Date***

_____________________________________ __________________________________

Signature of Personal Representative ***Personal Representative's Authority for Patient***

Staff Witness:________________________
Staff member who witnessed signature

Family Health Center of Mission
Authorization to Release Protected Health Information
To Family Member or other Designated Person

I ___________________________________, DOB: _____________________, authorize the release of any of my medical information

to ____, DOB:____________________.

Relationship to patient:____
Except to the extent that action has already been taken in reliance of this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer.

____________________________________ ________________________

Signature of Patient **Date**

Staff Witness:________________________
Staff member who witnessed signature