

BIRCH TREE PODIATRY GROUP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of this office's Notice of Privacy form.

Patient signature: _____ Date: _____
(Parent or guardian)

DOCUMENTATION OF FAILURE TO OBTAIN SIGNED ACKNOWLEDGEMENT

On _____, _____ presented this Acknowledgement of Receipt of Notice of Privacy form to _____ (patient).

The patient refused to provide a signature when requested.

RELEASE OF INFORMATION

I, _____ authorize Dr.'s Hartman, Lathrop to release and/or discuss information relevant to my care to the following individuals:

Name and relationship _____

Name and relationship _____

Name and relationship _____

I also authorize information about my health care, test results or other related messages to be left on my answering machine in the event that I am not available.

YES _____ NO _____

Phone Number _____