



PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that Optimum Health has made available to me the *Notice of Privacy Practices and Individual Rights*. A paper copy of this Notice will be provided at my request.

Initials: _____

Authorization to Release Protected Health Information

I, _____, hereby authorize Optimum Health to release my protected health information to the following: (Please check and provide the NAME or specific entities to whom your protected health information may be given.)

_____ Family members or friends: (please give names) _____

_____ School or Employer: (list names of school/coach/employer) _____

_____ Other: _____

Initials: _____

This authorization shall be in effect (please check one).

_____ no expiration date _____ expiration date of _____

Patient Name (printed)

Patient Signature

Date

Parent/Guardian Name (printed)

Parent/Guardian Signature

Date

Witness Name (printed)

Witness Signature

Date

Office Use – Documentation of Good Faith Effort

The patient identified above was made aware of the availability of the Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgment of this. However, acknowledgment has not been obtained because:

_____ Patient refused to sign the Privacy Notice Acknowledgment

_____ Patient was unable because: _____

_____ There was a medical emergency. Provider will attempt to obtain acknowledgment as soon as practical

_____ Other reason, describe: _____

Optimum Health Employee Printed Name

Optimum Health Employee Signature