Drs Coombs & Ross
Consent for Disclosure of Health Information

Authorization: We must disclose your health information to you, as describe in our Notice of Privacy Practices. By signing this Consent form, you are giving consent to disclose health information to a family member, friend, or other person to the extent necessary to help with your treatment, payment activities and healthcare operations.

Patient Name_____Date of Birth_____

Signature_____Date_____
(You are entitled to a copy of this Consent after you sign it.)

Please release information to the following:

_____ _____ _____
Name Date of Birth Relationship to Patient

_____ _____ _____
Name Date of Birth Relationship to Patient

Right to Revoke: You may revoke this Consent at any time by giving us written notice.
**Please understand that revocation of this Consent will not affect any action we took in reliance of this consent before we received your revocation.*

Revocation of Consent:
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

Signature_____Date_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Print Name)

_____ _____
(Signature) (Date)

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:
___ Individual refused to sign
___ An emergency situation prevented us from obtaining acknowledgement
___ Other