DTC Family Health
Acknowledgment of Notice of Privacy Practices/Prescription History
HIPAA Release Form/Consent to Leave Messages/Office and Financial Policies

Patient's Name (Print): _____ Date of Birth:_____

Acknowledgment of Notice of Privacy Practices

By signing this form, I acknowledge receipt of DTC Family Health's Notice of Privacy Practices. I understand that the Notice of Privacy Practice contains information on the uses and disclosures of any personal health information and I have been given the opportunity to review the Notice. I understand that the terms of the Notice may change and that I will be given a revised notice if changes occur.

Documentation of Good Faith Efforts

(For use when Privacy Policy acknowledgment cannot be obtained from the patient.)

☐ Patient refused to sign.
☐ Patient was unable to sign or initial because: _____.
☐ Patient had a medical emergency. An attempt to obtain acknowledgement will be made at the next visit.
☐ Other: _____.

Prescription History Consent

By signing this form, I authorize DTC Family Health to obtain my prescription history from external sources to aid in medical history and treatment.

Release of Information

By signing this form, DTC Family Health has permission to release my personal health information regarding my medical care and/or account information to:

1) Name: _____ Relationship to Patient _____
2) Name: _____ Relationship to Patient _____
3) Name: _____ Relationship to Patient _____

This Release of Information will remain in effect until revoked by me in writing or until I have completed a new HIPAA Release Form.

Consent to Leave Messages

Please call phone number: _____ which is my (☐) Home (☐) Work (☐) Cell

If unable to reach me: (☐) Leave a detailed message (☐) Please leave a message asking me to return your call.
(☐) Other_____

My signature below indicates that I have read and agree to following:
DTC Family Health's Notice of Privacy Practices
DTC Family Health to obtain my prescription history
DTC Family Health has permission to release my personal health information as stated above
DTC Family Health has consent to leave messages as stated above
DTC Family Health Office and Financial Policies

Signature: _____ Date:_____
(Signature of Patient or Guardian)