Family Practice Associates

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Acknowledgment of Privacy Practices

I, _____, have received a copy of Family Practice Associates Notice of
(print patient name)
Privacy Practices.

(The portion below is optional. Fill out only if you want others to be able to obtain/ discuss your medical records.)

I, _____, give permission to the following person(s) to obtain any/all medical
(print patient name)
information on myself/patient.

Name: _____, Relation: _____

Name: _____, Relation: _____

Name: _____, Relation: _____

Name: _____, Relation: _____

❑Yes, I am giving permission to the above stated individuals to discuss and obtain protected health information about myself/patient and I understand that I may revoke this permission in writing at any time.

❑No, I do not want to give anyone permission to discuss or obtain protected health information other than other physicians and medical facilities at this time.

_____ _____/_____/_____ _____
Patient/Guardian Signature Patient Date of Birth Today's Date