Southwest General Medical Group, Inc.

NOTICE OF PRIVACY PRACTICE

Acknowledgement of receipt of notice of privacy practices

I hereby acknowledge that I received the Notice of Privacy Practices of Southwest General Medical Group, Inc. which sets forth the ways in which my electronic personal health information may be used or disclosed by Southwest General Medical Group, and which outlines my rights with respect to such information.

_____ _____ _____

Print Name **Signature** **Date**

Patient DOB _____

1. I would like the person specified below (family member or friend) to have access to my medical information. My signature below gives the doctor and staff of Southwest General Medical Group, Inc my permission to discuss test results and /or my health status with that individual.

_____ _____

Signature **Date**

_____ _____

Specified Person (print name) **Relationship**

OR

2. My signature below indicates that I DO NOT give my permission to release information about my health to anyone other than the insurance company and myself.

_____ _____

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
- ☐ Communication barriers prohibit obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement

Other (please specify): _____

- ☐ Noted in EHR- consents
- ☐ Scanned into EHR medical record by _____