Drs. Delaney, Root & Associates, P.C.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgment

I acknowledge that I have today received a copy of this office's Notice of Privacy Practices.

_____
Patient(s) Name(s)

_____
Please Print Name of Person Signing

_____ _____
Signature Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I consent to your disclosures of information which you deem are necessary in connection with the treatment for the patient(s) listed above.

_____
Please Print Name of Person Signing

_____ _____
Signature Date