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BISCHOFF

HAND SURGERY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:

_____

I hereby acknowledge that I have received a copy of Bischoff Hand Surgery Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I choose.

_____ _____

Signature of Patient or Legal Representative *Date*

_____ _____

Printed Name of Patient's Representative *Relationship to Patient*

Medical Information Release Form
(HIPAA Release Form)

I authorize the release of information including the diagnosis, records; examination rendered to and claims information. This information may be released to the following:

_____ _____

Name *Relationship to Patient*

_____ _____

Name *Relationship to Patient*

Relationship to Patient

_____ _____

Signature of Patient or Legal Representative *Date*