Island Neurological Associates, P.C

Notice of Privacy Practices Acknowledgement

I have received a copy of the Notice of Privacy Practices which describes how my protected health information is used and disclosed by this practice.

_____ _____

Signature of patient **Date**

_____

Print Name

Disclosure Consent

I, _____give permission for the Physicians
NAME OF PATIENT (print)

and staff of Island Neurological to discuss my medical condition with the following family member and allow him/her to pick up medical records, prescriptions or any other material I may need and can not do myself.
(add more names on back)

_____ _____

Name **Relationship**

_____ _____

Name **Relationship**

I understand that I may revoke this consent in writing by contacting this office, attention Privacy Officer.

_____

OFFICE USE ONLY
I have attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practice Acknowledgement, but was unable to do so as documented below

Date	**initials**	**reason**