Acknowledgement of Receipt

Please fill in ONE of the following:

I acknowledge that I have been informed of the Heath Insurance Portability and Accountability Act (HIPPA/HIPAA)

Name of patient:

Signature:_____

OR

I acknowledge that I have been informed of the Heath Insurance Portability and Accountability Act (HIPPA/HIPAA)

I release my information to my immediate family members i.e. Mother, Father, Spouse Adult Children. Please list who it is ok to speak with:

*(Name/Relation)-
*(Name/Relation)-

Name of patient:

Signature:_____

OR

I acknowledge that I have been informed of the Heath Insurance Portability and Accountability Act (HIPPA/HIPAA)
I release my information to my Caretaker :

Name of patient:

Signature:_____