MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF

PATIENT NOTICE OF PRIVACY PRACTICES
(HIPAA)

I acknowledge that I received a copy of the Michigan Healthcare Professionals, P.C. Patient Notice of Privacy Practices effective September 23, 2013.

Patient Name: _____ Date of Birth: _____

Date: _____ Patient Signature: _____
(or Guardian, if applicable)

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_____ I DO NOT wish to have any of my medical information disclosed with anyone at this time.

_____ I would like my physician to be able to discuss my medical condition with family, relatives, and friends that I identified as being involved with my healthcare. I wish to have the following individual's authorization, to share my health information.

Please list these individuals below:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Date: _____ Patient Signature: _____
(or Guardian, if applicable)