CHRISTIAN COMMUNITY HEALTH CENTER

ACKNOWLEDGEMENT OF CONSENT(S)

Patient Name: _____ **DOB**: _____ **Medical Record #:**_____

My signature below acknowledges that I have read and/or been offered a copy of the Privacy & Confidentiality Practices Notices listed below. I am aware that a copy of the current notices are posted and that I can request copies of the documents listed below. Please read and initial each statement below.

AUTHORIZATION TO RELEASE BENEFITS

I have read the terms and conditions of the Authorization to Release benefits and fully agree to each of the statements and agreements therein.

_____ Initials

CLIENT/PATIENT CONFIDENTIALITY STATEMENT

I hereby acknowledge that I have read and/or been offered a copy of the Client/Patient Confidentiality Statement, I understand its contents and agree to all the provisions contained therein.

_____ Initials

CLIENT/PATIENT GRIEVANCE PROCEDURE

I hereby acknowledge that I have read and/or been offered a copy of the Client/Patient Grievance Procedure, I understand its contents and agree to all the provisions contained therein.

_____ Initials

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read and/or been offered a copy of the Notice of Privacy Practices. I have been made aware that the Notice of Privacy Practices details information about how the practice may use and disclose my confidential information for treatment (including continuing care received from other treatment providers or facilities), billing and health care operations.

_____ Initials

_____ _____ _____ _____

Signature of Patient Date Authorized Signature (Parent/Guardian) Date

Rev. 7/2019