# Complete Family Medicine, LLC

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## Acknowledgement of HIPAA Privacy Notice

I have been presented with a copy of Complete Family Medicine's Notice of the HIPAA Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____Date: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____

Witnessed by: _____

IF PATIENT REFUSES TO SIGN, INDICATE YOUR ATTEMPT TO OBTAIN A SIGNATURE BELOW.

- Patient refused to sign this Acknowledgement.

Date: _____ Time: _____

Employee name: _____