INDIANA INTERNAL MEDICINE CONSULTANTS

WRITTEN ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES OF INDIANA INTERNAL MEDICINE CONSULTANTS

Patient's Name: _____
Last First Middle Initial

Date of Birth: _____

I hereby acknowledge that I have received the Notice of Privacy Practices of Indiana Internal Medicine Consultants dated April 14, 2003.

_____ _____
Signature of Patient (or Healthcare Representative) Date

_____
Printed Name of Healthcare Representative

_____
Relationship to Patient

PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION TO THOSE INVOLVED IN THE PATIENT'S CARE AND FOR NOTIFICATION PURPOSES

I, _____, request that Indiana Internal Medicine Consultants disclose to the following family members or friends my protected health information that is directly relevant to such person's involvement with my care or payment related to my care. Indiana Internal Medicine Consultants may also use or disclose this information as necessary to notify the following individuals of my general condition, location or death.

_____
_____

_____ _____
Signature of Patient (or Healthcare Representative) Date

If patient is unable to sign, but circumstances are such that it can be reasonably inferred that the patient intends to consent to such disclosure, so note by checking and initialing here: □

_____

A copy of this written acknowledgment shall be placed in the medical record.