

**Acknowledgement of Receipt of Privacy Notice
Paris Family Physicians, P.A.**

I have been presented with a copy of Paris Family Physicians, P A 's **Notice of 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. I request payment of medical insurance benefits, including Medicare, Medicaid or other health plans, as these apply to me, to Paris Family Physicians, P.A. Regulations pertaining to medical assignment of benefits apply. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize Paris Family Physicians, P.A. to release, either by mail, fax or phone, any personal health information necessary to secure payment or as necessary to provide treatment or for other healthcare operations of Paris Family Physicians, P.A..

I also understand that by refusing to sign this consent or revoking this consent, Paris Family Physicians, P.A. may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I understand Paris Family Physicians, P.A. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Patient Name: _____ **DOB:** _____

Signed: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient (e.g., Legal Representative or Parent)

Relationship: _____

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By: (name and title): _____