

MAPLE MEDICAL, TMLLP

Pulmonary, Critical Care, Internal Medicine, Endocrinology, Cardiology, Nephrology & Gastroenterology

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____ have received a copy of the HIPAA Privacy Notice.
PLEASE PRINT

Patient Signature

Date

The privacy regulations require Maple Medical, LLP with direct treatment relationships make a good faith effort to obtain an individual's written acknowledgment of the receipt of the Practice's privacy notice at the time of the first service delivery (except in emergencies).

PERMITTED DISCLOSURE OF INFORMATION TO FAMILY

I authorize Maple Medical, LLP to disclose information regarding my medical condition and care to the following:

Name

Relationship

Name

Relationship

Name

Relationship

This authorization shall remain in effect unless revoked in writing

Patient Signature

Date

REASON IF ACKNOWLEDGEMENT IS NOT SIGNED:

EMPLOYEE WITNESS:

DATE: