

Chart # _____



1110 Cottonwood Lane • Suite 100 / 200 • Irving, Texas 75038 • Phone: (972) 258-7499

HIPPA PRIVACY ACT INFORMATION FORM

Please check one of the boxes below for release of medical information:

Release information only to me: Yes No

Release information to my spouse: Yes No

Spouse's Full Name: _____

Release Records to other: Yes No

Full Name: _____ Phone #: _____

Would you like for us to leave medical information on your answering machine? Yes No

Phone #: _____

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Healthcare Associates reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Healthcare Associates.

Name of Patient (Print)

Signature of Patient

Signature of Patient's Representative
(Required if the patient is a minor or an adult
who is unable to sign this form)

Relationship to Patient

Date