Medical Group

ACKNOWLEDGEMENT OF RECEIPT FORM

Health Insurance Portability and Accountability Act, [HIPAA]

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name____**Date of Birth:** ______________
(Please Print)

By signing below, I acknowledge receipt of or the opportunity to review the Notice of Privacy Practices of Virtua Medical Group. In addition, by signing below, I authorize Virtua Medical Group to disclose my health information in conformance with the provisions of the Notice of Privacy Practices.

Signature:____**Date:** ____________________

Phone Authorization

____**Yes, you have my permission to leave medical information on my answering machine. Please let us know which daytime telephone number is best to do so.**

(   )______________________________.

______**No, you do not have my permission to leave medical information on my answering machine.**

To whom, other than yourself, may we speak regarding your medical condition?

Name_______________________________________**Relationship** ____________________

Phone# ________________________

Name_______________________________________**Relationship** ____________________

Phone# ________________________

I have the right to withdraw or revise my permission at any time in writing.

Signature:____**Date:** ____________________

<u>For Office Use Only:</u>

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, indicate the reason why the acknowledgement was not obtained.

______**Individual refused to sign.**

______**An emergency situation prevented us from obtaining the acknowledgement.**

Signature of Virtua Representative: ____

Revised 3/11/16