Patient Acknowledgement Form
HIPAA Notice of Privacy Practices

Patient Name: _____ Date: _____/_____/_____

☐ I, _____, do hereby acknowledge receipt of a HIPAA Notice and Privacy Practices from First Choice Medical Group of Brevard, LLC (FCMG).

☐ I was offered a copy of the FCMG HIPAA Notice of Privacy Practices. I declined it.

I authorize the person(s) listed below to have access to any and all of my health information, including HIV, drug and alcohol abuse, and psychiatric records. FCMG is permitted to share any medical and/or billing information with them, including but not limited to test results and information disclosed during office visits, surgeries and/or procedures.

Person #1: _____ DOB: _____

Person #2: _____ DOB: _____

You may notify me of appointment and billing information as follows:

☐ Messages on answering machines ☐ Message on work voicemail

☐ Message on cell phone ☐ Email: _____

Patient Signature: _____ **Date:** _____/_____/_____