ARIA HEALTH GROUP

I hereby acknowledge that I have received a copy of the ARIA HEALTH GROUP Notice of Privacy Practices

Patient Name (Please print): _____

I give my permission to release medical information, like appointments, treatment and/or care information to the following individuals below (family or friends, no doctors):

Name: _____ Phone # _____ Relationship: _____

Name: _____ Phone # _____ Relationship: _____

Signature: _____ Date: _____

If signed by a personal representative of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: ☐ Parent

☐ Legal Guardian

☐ Holder of a Medical Power of Attorney

Witness Signature: _____ Date: _____

For Office Use Only

DOCUMENTATION OF ATTEMPT TO OBTAIN WRITTEN ACKNOWLEDGMENT OF THE DELIVERY OF THE NOTICE OF PRIVACY PRACTICES

I delivered Aria Health Group Notice of Privacy Practices to this patient or his/her personal representative but was unable to obtain an acknowledgment of the receipt of Notice of Privacy Practices because:

- ☐ Patient was unable to sign due to _____
- ☐ Patient refused to sign
- ☐ Notice of Privacy Practices acknowledgment was mailed to patient

Other: _____

Employee Name: _____ Employee Signature: _____

Date: _____