BERGEN
MEDICAL ASSOCIATES
A Premier Medical Alliance Partner

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____ , have received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

For Office Use Only

Patient's Number: _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

****You May Refuse to Sign This Acknowledgement****

MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE NOTICE)

Name: _____ **DOB**: _____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Name	Relationship	DOB	Phone Number

☐ Information is not to be released to anyone

This **Release Of Information** will remain in effect until terminated by me in writing

By signing this form you are acknowledging the release of information to all partners of Premier Medical Alliance, except our Gynecology office. You will be required to sign a second release form when seeing our gynecologists.

Signature: _____ Date: _____

Witness: _____ Date: _____