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ACKNOWLEDGEMENT and CONSENT
FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you acknowledge receipt of our Notice of Privacy Practices and consent to our use and disclosure of your and/or your children's protected health information.

SECTION A: PATIENT GIVING CONSENT

Name:_____Date of Birth_____

Address: _____

Home Telephone: _____
Work#:_____Cell#:_____

SECTION B: PLEASE READ CAREFULLY

As a courtesy, we may leave messages regarding your appointments, insurance, or related information. Please let us know how we should contact you and what information we may leave.

PLEASE CONTACT ME AT: _____
(Phone or Email)

I give permission to leave messages regarding: ☐ Appointments Only ☐ All Information ☐ DO NOT LEAVE MESSAGES

On occasion spouses, parents, significant others, or other extended family members may require/request information regarding insurance, appointments, or other health related information. Please list all persons whom we may give or discuss your health and other pertinent information with.

Name_____Name_____

_

Relationship_____Relationship_____

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SECTION C: SIGNATURE I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to your use and disclosure of my protected health information.

Signature X_____ **Date:**

1570 Union St, Schenectady, New York 12309
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