Dr.Paul's Clinic

Acknowledgement of Notice of Privacy Policy

I understand that this acknowledgement is not a requirement to receive treatment at Dr.Paul's Clinic. I agree, under federal guidelines of the HIPAA Privacy Notice, that I have been given the option and opportunity to read and have any questions answered about the Notice of Privacy Practices and Dr.Paul's Clinic. I acknowledge receipt of the Notice of Privacy Practice with information on how Dr.Paul's Clinic may use and disclose my protected health information. I understand that Dr.Paul's Clinic reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

- I give permission for Dr.Paul's Clinic to leave a message with my health information via (check all that apply)
  - Phone: Preferred Number:___________________
  - Family Member: Name:_____________________
  - Email

☐ I DO NOT give my permission for Dr.Paul's Clinic to leave a message with my health information

Signature: **DATE:**

AUTHORIZATION TO TREAT:

By signing this document, I, being the patient or legal guardian authorize Dr.Paul's Clinic to provide medical care in accordance with currently accepted medical standards and guidelines.

SIGNATURE: **DATE:**

CONSENT TO TREAT A MINOR (IF APPLICABLE)

I confirm that I am the parent or legal guardian of the above minor. I authorize Dr.Paul's Clinic to provide medical care as it deems necessary to the minor. In the event that the minor has received treatment previously at Dr.Paul's Clinic I authorize treatment in addition to that received on any previous date.

SIGNATURE: **DATE:**

OFFICE USE ONLY:

An effort has been made to obtain written acknowledgement of receipt of the privacy practices but could not be obtained for the following reason:

However, this did not prevent the patient from being seen and/or treated at Dr.Paul's Clinic.

Employee Signature: