

ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES

I, _____ DOB _____, acknowledge that I have been notified of this practice's privacy policy that includes medical and prescription history, and a written copy of this policy has been made available to me. I authorize medical treatment as deemed necessary and appropriate by the medical providers of **IM / Health** and their employees participating in my care.

Patient's Signature

Date

CONSENT TO RELEASE MEDICAL INFORMATION

I, hereby authorize the disclosure of my protected health information (including but not limited to results, prescriptions, and appointment) to the person(s) listed below.

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

I hereby authorize the practice to leave health information and appointment reminders on

Phone Number: _____ Home/Cell/Work

€ I allow IM Health to leave messages on this phone number.

€ I allow IM Health to text this phone number.

€ Web enable email address