

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.

Signature of Patient or Legal Guardian 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 PT to leave messages on this phone number.

€ I allow IM Health PT to text this phone number.

