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.

____

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.