



*For office use*

Patient \_\_\_\_\_

Account \_\_\_\_\_

Received by \_\_\_\_\_

## Acknowledgment of Receipt of Privacy Notice

I acknowledge that I have received a copy of Pulmonary Medicine Associate's *Notice of Privacy Practices*.

\_\_\_\_\_  
Signature of Patient or Legal Representative\*\*

\_\_\_\_\_  
Date

## Authorization to Release Medical Information

We understand that there are times when you may want a family member or friend to act as your representative for things such as picking up prescriptions, making or canceling appointments and speaking with our staff or physicians. Please help us protect your privacy by providing their names below.

Pulmonary Medicine Associates may release medical information to:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Please indicate any specific information that you **do not** want released to the above listed people. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Representative\*\*

\_\_\_\_\_  
Date

*\*\*Patient, patient's legal guardian or legal power of attorney (provide a copy of POA).*