Todd S.
HARRIS, MD

Acknowledgement and Authorization

Name: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS & RESPONSIBILITIES

The practice reserves the right to modify the privacy practices outlined in this notice

[ ] By Checking This Box I or My Legal Representative Hereby acknowledge that I have read the **Notice of Privacy Practices**. (A copy may be given to you upon request.)

[ ] By Checking This Box I or My Legal Representative Hereby acknowledge that I have read the **Notice of Patient Rights & Responsibilities**. (A copy may be given to you upon request.)

I agree to accept financial responsibility for services rendered to the patient.

Signed By Patient/ Legal Representative: _____

AUTHORIZATION TO COMMUNICATE YOUR MEDICAL INFORMATION

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kind of information may be shared with each individual.

☐ None

or

☐ Name and type of information

NAME	RELATIONSHIP TO YOU	ALL	SCHEDULING/ APPOINTMENT	MEDICAL	BILLING/ INSURANCE

We will continue to rely on the information on this form when communicating with your family members or others involved in your care unless you request changes. ***You are authorizing those listed to receive your protected health information.*** Please promptly notify our office if you wish to alter the designations above.

Signed By Patient/ Legal Representative: _____

Date: _____