ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of St. Clair Specialty Physicians, P.C. Notice of Privacy Practices on the date indicated below.

Patient Name:_____ **Birth Date:**_____

Signature:_____ **Date:**_____

Information about Agent (attach appropriate documentation):

Agent:_____ **Title:**_____

CONSENT FOR RELEASE OF MEDICAL RECORDS

I hereby authorize SCSP to discuss My Health Information with:

_____

Name(s)

For this Authorization, "My Health Information" means (check one or more):

_____All Records (clinic notes, diagnostic testing/results, history and physical, billing, immunization, mental health, etc.)

_____Other (Please Specify):_____

I understand that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- This Authorization is valid unless I revoke/withdraw this Authorization or unless an earlier date is specified here: _____. I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to SCSP.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature of Patient Only: _____Date:_____

For Office Use Only:

____Patient/Representative Unable to Sign - Notice of Privacy Practices Provided

____Patient/Representative Refused to Sign - Notice of Privacy Practices Provided

____Other_____

Staff Name:_____Signature:_____Date:_____