AKLILU & COBIAN INFECTIOUS DISEASES, LLC
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of Notice of Privacy Practices.

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY:

We have attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign.
_____ Communication barriers prohibited obtaining the acknowledgement.
_____ An emergency situation prevented us from obtaining acknowledgement.
_____ Other: _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment and payment activities.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, healthcare operations, uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting our office.

Right to Revoke. You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if this consent is revoked.

I, _____, have had the opportunity to read and consider the contents of this consent form and the Notice of Privacy Practices. I understand, that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment and payment activities. I authorize the following people to receive medical records and/or information regarding my health at any time.

_____ _____
Name Relationship Name Relationship

Patient Signature: _____ Date: _____

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