Memorial Medical Group

HIPAA Consent

ACKNOWLEGEMENT OF NOTICE OF PRIVACY PRACTICES

I, individually or on behalf of the patient, authorize Memorial Medical Group (MMG) to use and disclose my health information as required for treatment, payment, and healthcare operations as described in MMG's Notice of Privacy Practices. I hereby acknowledge that I was given a copy of the Notice of Privacy Practices.

Patient Name: ________________________________ (Please print.) Patient Date of Birth: ____________

Signature: ____ Date: _____________________
Hereby acknowledge that I was given a copy of the Notice of Privacy Practices and refused to accept.

Signature: ____ Date: _____________________
Hereby acknowledge that I was given a copy of the Notice of Privacy Practices.

Relationship (if not signed by patient):____

METHOD OF COMMUNICATION

May we leave a message with any person answering your telephone if you are not available? □Yes □No
May we reach you by cellular phone? □Yes □No Cellular #___________________________
May we call your place of employment? □Yes □No Work #___________________________
May we confirm your appointment via text message? □Yes □No
May we confirm your appointment on your answering machine? □Yes □No
May we confirm your appointment with someone other than yourself? □Yes □No
If yes, please specify.

______________________________ ______________________ ___________________________
Name Relationship to patient Phone Number Including Area Code

______________________________ ______________________ ___________________________
Name Relationship to patient Phone Number Including Area Code

RELEASE OF MEDICAL/BILLING INFORMATION

______________________________ ______________________ ___________________________
Name Relationship to patient Phone Number Including Area Code

______________________________ ______________________ ___________________________
Name Relationship to patient Phone Number Including Area Code

RELEASE OF PRESCRIPTIONS

****List individuals you designate to pick up your written prescriptions from this office on your behalf. The individual must present ID at time of pick up:**

______________________________ ______________________ ___________________________
Name Relationship to patient Phone Number Including Area Code

______________________________ ______________________ ___________________________
Name Relationship to patient Phone Number Including Area Code

____________________________________ _________________________

Memorial
Medical Group

Signature Date