C.C. MEDICAL SERVICES
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Acknowledgement of Receipt of Notice of Privacy Practices

As a result of the Health Insurance Portability and Accountability Act (HIPPA), enforced by the U.S. Department of Health and Human Services Office for Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices. We are legally required to give you this Notice of Privacy Practices and must obtain a signed statement that you received it. By signing this form, you are saying that you received C.C. Medical Services Notice of Privacy Practices.

* I_____ acknowledge receipt of the Notice of Privacy Practices for C.C. Medical Services.

* _____ * _____
Signature of Patient, Guardian or Representative Date

* _____ * _____
Relationship to Patient Date

I give authorization for health information to be discussed with:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

Information will NOT be disclosed unless the individual is listed above and the acknowledgement is signed by the patient / representative.