Acknowledgement of Receipt of Privacy Policy
(to be filed in patients medical records)

I have been presented with the notice of the Privacy Practices, detailing how my health information may be used and disclosed, under Federal and State law, and outlining my rights regarding my health information

Signed: ___________________________________ Date: ____________________

Relationship (if not signed by patient): ___________________________________

I may request a copy of the Privacy Practices if I so desire.

If the patient/patient representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below

Presented on: ______________________________ Time: ___________________

Signature on File Form

I authorize the release of any pertinent information to my insurance company/companies and the use of this signed form for submission to my insurance company/companies. I understand that I am responsible for my bill, and hereby authorize Northern Litho Inc. to act as my agent in helping me obtain payment from my insurance company/companies. In addition, I authorize payment directly to Northern Litho Inc. for services rendered and for a copy of this authorization/signature to be used in place of the original.

Name: ____ Medicare# ___________________

Signature: ______________________________________ Date: _______________________