Lake Kiowa Medical Clinic

Acknowledgement of Review of Notice of Privacy Practices

I have been given the opportunity to review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority

COMMUNICATIONS AUTHORIZATION AND RELEASE OF INFORMATION TO FRIENDS OR FAMILY MEMBERS

Name of Patient_____Date of Birth_____

Chart Number_____

1. DO WE HAVE PERMISSION TO:
   Leave a message on your home answering machine concerning Laboratory, X-ray or other such diagnostic results? YES OR NO

2. CAN WE CONTACT YOU AT WORK REGARDING:
   Appointments, lab results or other health care issues? YES OR NO

3. LIST NAMES OF FAMILY MEMBERS OR FRIENDS TO WHOM WE MAY DISCUSS HEALTH CARE ISSUES:

   Name:_____Relationship:_____

   Name:_____Relationship:_____

   Name: _____Relationship:_____

4. PERSON WHO IS RESPONSIBLE OR GUARDIAN FOR THE HEALTH OF AGED PARENT, DISABLED INDIVIDUAL, ETC.

   Name:_____How Authorized:_____

5. PERSON WHO MAY BE PRESENT WHILE IN AN EXAMINATION, DISCUSSION, OR OTHER HEALTH CARE PROCEDURE:

   Name:_____Relationship:_____

6. PERSON WHO MAY PICK UP PRESCRIPTIONS, EQUIPMENT, OR OTHER HEALTH CARE INFORMATION:

   Name:_____Relationship:_____

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority