For Office Use Only
**Patient Acct #:** _____

# Acknowledgment of Receipt of Privacy Practice Notice For Metropolitan Pulmonary, P.C.

I acknowledge, by my signature below, that I have received a copy of Metropolitan Pulmonary's Notice of Privacy Practices.
(These forms are located in our waiting room & our website.)

**WHO MAY RECEIVE INFORMATION REGARDING YOUR HEALTH INFORMATION? (Check all that apply)**

___ Spouse Full Name: _____

___ Children Full Name(s): _____

_____

___Physician Full Name(s): _____

_____

___ Other Full Name(s): _____

_____

By my signature, I authorize the above list of persons to receive my Protected Health Information per HIPAA requirements. I understand this consent and authorization may be revoked at any time except to the extent already acted upon.

***This consent and authorization expires in (please circle one) 90 days from date signed, lifetime, or other _____.*** A copy of this consent and authorization shall be considered as effective and valid as the original.

***Printed Name of Patient:*** _____ ***D.O.B.*** _____

***Signature of Patient*** _____ ***Date*** _____

Witness _____ Date _____