



COMMUNICATION AUTHORIZATION FORM

When it comes to your medical treatment, we strive to communicate with you in a timely and professional manner. There are certain occasions when family members or friends might be involved in your care. As a patient you will want our staff to be able to communicate directly with them. In order to protect the privacy of your personal health information, please share with us the names of those individuals with whom we can discuss your care and share your protected health information.

En su tratamiento medico, nosotros nos esforzamos para comunicarnos con usted en una manera oportuna y profesional. Hay ciertas ocasiones cuando miembros de su familia o sus amigos quizás sean implicados en su cuidado. Usted querrá que nuestro personal sea capaz de comunicarnos directamente con ellos. Para proteger la privacidad de su información personal, por favor denos los nombres de esos individuos con quien podemos discutir su cuidado y compartir la información de su salud.

Name: _____
Nombre

Relation to patient: _____
Relacion al paciente

Name: _____
Nombre

Relation to patient: _____
Relacion al paciente

Name: _____
Nombre

Relation to patient: _____
Relacion al paciente

Signature of Patient or Legal Representative
Firma del Paciente o Representante Legal

Relationship
Relacion

Date
Fecha

ACKNOWLEDGMENT OF PRIVACY NOTICE

I acknowledge that I have been offered the notice of Privacy Practices.
Se me ha ofrecido el Anuncio de Privacidad

Signature of Patient or Legal Representative
Firma del Paciente o Representante Legal

Relationship
Relacion

Date
Fecha

DOCUMENTATION OF GOOD FAITH EFFORTS

On this date, the above named patient was treated and given a copy of the Notice of Privacy Practices. An attempt was made to obtain a written acknowledgment of receipt of the notice, however, acknowledgment was not obtained because:

[] Patient refused to sign.

[] Patient was unable to sign due to: _____

Signature of Employee/Witness