Greystone Medical Clinic
Notice of Privacy Practices Acknowledgement

A Joint Notice of Privacy Practices is provided to all patients. This notice of privacy practices identifies: (1) How medical information about you may be used or disclosed; (2) Your right to access you medical information, amend your medical information, request an accounting of disclosures of you medical information, and request additional restrictions on our used and disclosures of that information; (3) Your rights to complain if you believe your privacy rights have been violated; and (4) Our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

Name of Patient _____ Patient's Date of Birth _____

Patient's Telephone Number _____

Name of Patient's Parent/Guardian (If Patient is under the age of 18) _____ Signature of Patient's Parent/Guardian _____

Signature _____ Date _____

Disclosure of Information

In cases requiring disclosure of medical information to someone other than the patient the following authorization must be completed:

Name of the SPECIFIC INDIVIDUAL(S), (example: family members or friends) to whom the information may be disclosed along with relationship to patient and a TELEPHONE NUMBER for same.

Name _____ Relationship _____ Telephone Number _____

Name _____ Relationship _____ Telephone Number _____

Signature _____ Date _____