ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have reviewed a copy of the Notice of Privacy Practices of Falcon Health Center/Wood Health Company and understand that my protected health information may be used by the Practice as described in the Notice.

✓Patient Signature: ________________________________ Date:________________

Patient Name:________________________________ Date of Birth:___/____/____

Consent to Release of Information REQUIRED if you would like us to discuss your healthcare with someone other than you

The HIPAA Privacy Regulations require that we obtain your consent to discuss your healthcare or financial information related to your care. **The right to disclose information to the below noted individual(s) will remain in effect until revoked in writing, by you.**

Spouse:	**YES**	**NO**	**Spouse Name:** ________________________________
Child:	**YES**	**NO**	**Child Name(s):** ________________________________
Other:	**YES**	**NO**	**Name/Relationship:** ____________________________
Electronic Data:	**YES**	**NO**	**E-mail Address:** ________________________________

✓Patient Signature: ________________________________ Date:________________