ACKNOWLEDGEMENT OF RECEIT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided with a copy of Guilford Immediate Care Notice of Privacy Practices. The notice contain information regarding potential uses and disclosures of my protected health information (as that term is defined under the Health Insurance Portability and Accountability Act of 1996 "HIPPA") that may be made by the practice, and of my rights and the practice's legal duties with respect to my protected health information. I have had the opportunity to review the notice and take a copy with me if I so choose.

O I **do not** authorize the release of my medical information, to anyone.

O I authorize the release of my medical information to the individual(s) listed below:

_________________________ (individual) ____________ (relationship)
_________________________ (individual) ____________ (relationship)
_________________________ (individual) ____________ (relationship)
_________________________ (individual) ____________ (relationship)

_________________________ _________________________ ____________
Patients Printed Name Patient/Parent Signature Date

Patient Refusal to Sign Document:
If the patient refuses to sign acknowledgement, Complete this section:
_____ Patient refuses to sign Acknowledgement (HIPPA) Document

____ This Guilford Immediate Care employee made the following attempts to acquire a signature from the above mentioned individual:

____
____
____

_________________________ _________________________ ____________
Employee Signature Employee Printed Name Date

____
Office Manager / Privacy Official GIC