Patient Name: _____

I acknowledge that I have received a copy of the Rochester Urgent Care Notice of Privacy Practices and have been advised of how the facility will handle my Protected Health Information. I understand that I may receive other notices that describe how the facility will handle specialized forms of Protected Health Information such as HIV/AIDS, alcohol and substance abuse, genetic information and psychotherapy notes.

SIGNATURE

I have received a copy of the Rochester Urgent Care Notice of Privacy Practices. I have had an opportunity to ask questions about the Notice and the use or disclosure of my Protected Health Information.

Signature of Patient or Authorized Representative:_____

Print Name of Authorized Representative: _____

Authorized Representative Relationship to Patient: _____

CONTACT INFORMATION

Contact information of the authorized representative who signed this form:

Address: _____

Telephone: _____(Daytime) _____(Evening)

For Office use only:
Date Notice Provided: _____
Name of Staff Member: _____