COLORADO INTERNAL MEDICINE

A Concierge Medical Practice

Authorizations:

I, ___________________________________ acknowledge that I received a copy of the Privacy Practices of Colorado Internal Medicine ("Practice").
By signing this form, I acknowledge that the Practice has provided me with its Notice of Privacy Practices which explains how my health information may be handled in various situations including treatment, healthcare operations, payment and administration of plans. If my first date of service was due to an emergency, the practice will try to provide me with its Notice and obtain my written acknowledgment for the Notice as soon as possible once the emergency has passed. My signature also authorizes the Practice to use or disclose my health information for research and other purposes, as described in the Notice.

Signature ___________________________________ Date _______________________

Print Name ___________________________________

Patient Representative (if unable to sign)

Signature ____ Date _______________________

Print Name _____________________________ Relationship to Patient ______________________

For Office Use Only:
Complete if acknowledgment of receipt of Notice of Privacy Practice is not obtained.
I personally delivered the Notice of Privacy Practice to the patient/client listed above and made a good faith effort to obtain this written Acknowledgment.
The reason that a written Acknowledgment of receipt of the Notice by the patient/client was not obtained was due to:

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Print Name ___________________________________Signature_____________________________