Broomfield Pediatrics & Internal Medicine

Patient Acknowledgement of Receipt of Notice of Privacy Practices
And Consent / Limited Authorization & Release Form

You may refuse to sign this acknowledgement & authorization.
In refusing *we may not be allowed* to process your insurance claims or to contact you regarding appointments, results or billing.

Date: _____ Name of patient (**print**): _____ DOB: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR INFORMATION BE SENT TO OTHER PROVIDERS / FACILITYS IN THE FUTURE. I fully understand that this consent will remain valid until revoked in writing by me.

Please *sign* your name: _____ Date of Birth: _____

Parent/Legal Representative: _____ Description of Authority: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes parents, step parents, grandparents, spouses, significant others, and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If you need more space please list them on the back of this form

I, _____, give my permission for Broomfield Pediatrics & Internal Medicine to leave phone messages and/or text messages regarding my medical care/account information.

What phone # would you prefer to be informed that test results are available, give appointment reminders or with billing questions and to contact our office for more information?

_____ Phone Phone Number: _____ (Cell / Home / Work – circle one)

If you would like to get on our email list for notifications of changes at the office, flu clinics, special events, etc, please print your email clearly below.

Email: _____

If we start to text appointment reminders, what cell phone # should we text to? _____

Office Use Only

As Privacy Officer or representative, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because: _____ It was emergency treatment _____ I could not communicate with the patient
_____ The patient refused to sign _____ The patient was unable to sign because _____
_____ Other (please describe) _____

_____ Signature of Privacy Officer or Representative