Rosemary Delgado, M.D.

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended of Privacy Practices will be available at each appointment.

Signed: ____ Date: ____________________

Print Name: ____

☐

If not signed by the patient, please indicate relationship of who signed:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

DISCLOSURE TO OTHERS

I hereby authorize Rosemary Delgado, M.D. To discuss / reveal the following personal protected health information with the person (s) listed below:

( ) Any or all of my medical care, treatment and/or test results

( ) Same as above except: ____

( ) Only the following: ____

Authorized person(s):

Name	Date of Birth	Relationship
__________________________________	____________________	____________________________
__________________________________	____________________	____________________________

Signed ____

☐ DECLINED: I DO NOT AUTHORIZE ANY DISCLOSURES TO OTHERS

Signed ____