



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Printed patient name: _____ **Birth Date:** _____

I understand that Dr. Torrey Rassfeld may need to use and disclose information about my health or medical problems for the purpose of arranging, conducting, or referring for my treatments, for obtaining payment for the services rendered to me and for the operations of the practice. I consent to the use of my information for the purposes of treatment, payment and healthcare operations.

I understand that my consent is not needed if the law requires Dr. Torrey Rassfeld to report some aspect of my protected health information to a government agency. Examples would include suspected abuse, communicable disease and potential for serious bodily harm to myself or others.

I acknowledge that I was provided a copy of Dr. Torrey Rassfeld’s full-length Notice of Privacy Practices to read and that I was provided a printed copy if desired.

Authorized Signature: _____ **Date:** _____

Relationship to patient: Self Parent POA

OPTIONAL

Sometimes friends or family members need to be involved in decision making. By completing this section, I give my consent for Dr. Torrey Rassfeld to give the checked information to the persons I have listed below:

What I want them to have access to if needed:

Person’s Name	Phone Number	Health Information	Billing Information	Appointment Schedule
_____	_____			
_____	_____			
_____	_____			
_____	_____			

Signature: _____ **Date:** _____

****Only needed if optional section is filled out****