Account # _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT TO TREAT

I have had the opportunity to read and consider the contents of the privacy policy. I acknowledge that a copy of MSD's Privacy Policy is available for me or my personal representative. I understand, by signing this form, I am confirming my written permission for the disclosure of my protected health information as described in the Privacy Policy, as warranted.

_____

Please Print **PATIENT NAME**

_____

Signature Relationship

_____

Date

If this consent is signed by a personal representative / parent on behalf of the patient, complete the following:

Personal Representative's / Parent's Name: _____

Relationship to Patient: _____

I authorize the release of my information to the specified person(s) involved in my care:

_____ Relationship to Patient: _____

_____ Relationship to Patient: _____