ADULT AND GERIATRIC CENTER OF SOUTH FLORIDA

This Office has a policy to keep patient information confidential. You may designate below if you want someone other than yourself to have access to your private health information.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Patient Name: _____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Adult and Geriatric Center of South Florida, LLC.

Patient Signature: _____ Date: _____

RELEASE OF INFORMATION TO PERSONS OTHER THAN MYSELF

I allow the people listed below to receive medical information about my condition at any time:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient Signature: _____ Date: _____