Shelby Medical Associates, P.A.
711 N. DeKalb Street
Shelby, NC 28150
(704) 482-1482 • Fax (704) 482-0811

ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices for the above named medical practice.

_____
Patient Signature

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

___ An emergency existed and a signature was not possible at the time.

___ The individual refused to sign.

___ A copy was mailed with a request for a signature by return mail.

___ Unable to communicate with the patient for the following reason: _____

_____

___ Other: _____

_____

Prepared By: _____

Signature: _____

Date: _____

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Shelby Medical Associates, P.A. is authorized to release protected health information (PHI) about the below signed patient to the entity named below, in keeping with the instruction of the patient.

CHECK ALL THAT APPLY

☐ **VOICE MAIL. Release financial account information, lab test results and radiology test results to my Voice Mail attached to my phone numbers listed with the practice.**

☐ **SPOUSE. Release financial account information, and all medical health information related to my care to my Spouse:** _____
Name Phone

☐ **OTHER. Release financial account information, and all medical health information related to my care to the following person:** _____
Name Phone

THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL REVOKED BY THE PATIENT.

I understand that I have the right to revoke this Authorization at any time and that I have the right to inspect or copy the protected health information as described in this document. I understand that such revocation is not effective if the information has already been disclosed, but will be effective going forward.

I understand that the information disclosed as a result of this Authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this Authorization and that my treatment will not be conditioned on signing.

_____
Signature of Patient or Personal Representative