C. RON BYRD M.D. P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

_____ _____
Please Print Name Date

_____
Signature

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

By signing this authorization, you agree that C. Ron Byrd, M.D. P.A. or its Business Associates may disclose your personal healthcare information to:

_____
Identify intended recipients

Information to be released: _____ Lab/XRay reports
_____ Full Medical Record

You have the right to revoke this authorization, in writing, at any time, except to the extent that C. Ron Byrd, M.D. P.A. has taken action in reliance on it. A revocation is effective upon receipt by C. Ron Byrd, M.D. P.A. of a written request to revoke and a copy of the executed authorization form to be revoked.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

C. Ron Byrd M.D. P.A. will provide the patient with a copy of this signed authorization.

Acknowledged and agreed to by:

Patient: _____ Date: _____

Print Name: _____