NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

I understand that Dr. Torrey Rassfeld & Dr. Sylvia Trotter 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 & Dr. Sylvia Trotter 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 & Dr. Sylvia Trotter'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 & Dr. Sylvia Trotter 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****