ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I, ____, acknowledge that I received a copy of the Notice of Privacy Practice for POTENTRx.

I understand that the provider has reserved the right to change its privacy practices as described in the Notice. In the event of any change in POTENTRx privacy practices, POTENTRx will revise the Notice. I understand that I can obtain a copy of the revised notice by writing to POTENTRx.

I understand that if I choose not to sign this acknowledgement, POTENTRx is still authorized to disclose individually identifiable health information for the purpose of providing treatment, billing or healthcare operations.

I understand that I have the right to request a restriction on POTENTRx use or disclosure of any or all Protected Health Information to any or all locations, entities, or persons. I further understand POTENTRX is not obligated to agree to my request. However, if POTENTRx does agree to my request, the agreement will become binding.

I authorize POTENTRx to leave voice mail messages concerning my health information (i.e., lab results, appointment instructions, etc.) at the following number: __________________________

I hereby designate the following individual(s) to receive communications from POTENTRx that may include health information about me:

____   _________________________
Name   Relationship to me

____   _________________________
Name   Relationship to me

____   __________________________
Signature of Client (or personal representative)   Date

Client Date of Birth: ___________________________________

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

Personal Representative's Name: ____

Relationship to Client: ____