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| --- | --- |
| Provider: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

I acknowledge that I have received the HIPAA Privacy Notice.

 **(PRINTED LEGAL NAME)**

Sign:

 Patient or Personal Representative Date

**Minor/Legal Representative**

If Personal Representative’s signature appears above, please describe Personal Representative’s relationship to the patient, in addition to copies of proper legal forms.

I authorize Elite Health & Fitness to give information when requested to: (list relationship)

First Name: Last Name:

Relationship:

Type of information to be released: Medical Billing

Based on this release, billing information may be given verbally, electronically, or in printed form. Medical information will be verbal only. I understand that when my information is released as a result of this authorization it is no longer protected by the federal privacy standards.