Notice of Privacy Practices

Acknowledgement and Consent

Name:_____ SS#_____

***Please initial on the line of all items listed below*:**

_____I Acknowledge that I have been provided a copy of Dr. Joshua Sullum M.D. notice of Privacy Practice and will be advised of how health Information is disclosed. I also will be advised about how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notice explaining special privacy practices that apply to (HIV) related information. Or alcohol and substance abuse treatment.

_____I Consent to the use and disclosure of my health information to treat me and arrange for my Medical care to seek and receive payment for services given to me. Also for the business operations of Dr.Sullum and the practice staff.

_____ _____
Signature of Patient Date

_____ _____
Print Name of Patient Description of personal rep. Authority

_____ _____
Print Name of Witness Witness Signature