Clarksville Primary Care Center, Clarksville VA
A Service of Community Memorial Healthcenter

PATIENT ACKNOWLEDGEMENT

I have been given a copy of Community Memorial Healthcenter's Notice of Privacy Practices that describes how my health information is used and disclosed.

_____ _____
Printed Name Date

_____
Signature of Patient or Legal Representative

_____
If signed by legal representative, relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient:

_____

For CMH - CPCC Use Only

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the patient's representative, please explain your efforts to obtain their Acknowledgement and the reason you could not obtain it:

_____

_____

PERSONALLY IDENTIFIABLE HEALTH INFORMATION AUTHORIZATION

I, _____, grant authorization to CPCC to release and/or discuss my confidential medical information to the following person(s). I understand that this may include information regarding my appointments as well as information relating to my health status and any health problems that I may have experienced or may currently be experiencing.

Name: Relationship:

_____ _____

_____ _____

_____ _____