# Temple Health Notice of Privacy Practices Acknowledgment Form

Patient Name: _____

Patient MRN: _____

This is to acknowledge that I have received a copy of the HEALTH INFORMATION NOTICE OF PRIVACY PRACTICES (HIPAA) BOOKLET.

Patient's Signature: _____

Date: _____

This is to advise my physician that I give permission for you to share any and all information concerning my medical and psychological conditions with

Name(s): _____

Relationship to patient: _____

My signature on this document gives you permission to speak with and discuss my care with these designated person/s.

Patient's Signature: _____