



ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE
 AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ DOB _____

I have been offered or have received a copy of MidState Medical Group's "Notice of Privacy Practices".

I hereby authorize MidState Medical Group to obtain electronic information concerning my prescription history.

Granted (Initials)

Declined (Initials)

I hereby authorize messages regarding my relationship with MidState Medical Group to be left on my answering machine or voicemail in the following order of preference:

- 1) Phone # (____) _____ Home/Mobile/Work (circle) Leave Messages: ____Y ____N
- 2) Phone # (____) _____ Home/Mobile/Work (circle) Leave Messages: ____Y ____N
- 3) Phone # (____) _____ Home/Mobile/Work (circle) Leave Messages: ____Y ____N

I hereby authorize MidState Medical Group to communicate with the following persons regarding my health care:

- 1) Name _____
 Relationship _____
 Messages containing medical information can be left with this contact person Yes/No (circle)
- 2) Name _____
 Relationship _____
 Messages containing medical information can be left with this contact person Yes/No (circle)

This authorization will be valid from this date until written notice of changes and/or cancellations is received in the offices of MidState Medical Group.

MidState Medical Group is part of Hartford Healthcare and as such will share a system wide electronic medical record. Your information may be shared with other providers involved in your care within this network.

If patient is a minor (under age of 18) this authorization must be signed by the patient's parent or legal guardian.

 Patient Signature

 Date

 Parent/Legal Guardian Signature

 Date