Darrell Parsons, M.D., P.A.
318 N. Alleghaney, STE 100
Odessa, TX 79761
432-640-2929 Office
432-640-2379 Fax

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____DOB:_____

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make good faith effort to obtain a written acknowledgment that this notice was received.

Therefore, I (the patient or personal representative of the patient) acknowledge that the office of Darrell Parsons, M.D., P.A., has provided me with a written copy of its Notice of Privacy Practices for Protected Health Information.

_____ Date ____/____/20____
Signature of Patient or Personal Representative (mm/dd/yyyy)

_____
Name of Personal Representative and Relationship to Patient if Applicable

<u>OPTIONAL</u> RELEASE of INFORMATION to FAMILY or FRIENDS:

If you desire, you may list the family members or others persons to who we may release any and all medical information. This may facilitate communication in case of abnormal results or illness, etc.

Name: _____ relationship _____

Phone #: Home:_____ Cell: _____ Work:_____

Name: _____ relationship _____

Phone #: Home:_____ Cell: _____ Work:_____

Name: _____ relationship _____

Phone #: Home:_____ Cell: _____ Work:_____

Name: _____ relationship _____

Phone #: Home:_____ Cell: _____ Work:_____

_____ Date_____/_____/20_____
Signature of Patient or Personal Representative (mm/dd/yyyy)

_____
Name of Personal Representative and Relationship to Patient if Applicable