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ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE,
RELEASE OF PRESCRIPTION HISTORY AND DESIGNATION OF DISCLOSURE

Print Patient's Name

Date of Birth

I. Acknowledgement of Privacy Practice Notice

I have received a copy of DeVito Internal Medicine and Pediatrics, LLC's Notice of Privacy Practices. I hereby consent to the use or disclosure of my protected health information by, or on behalf of, DeVito Internal Medicine and Pediatrics, LLC for purposes of treatment, payment or healthcare operations. I understand that my protected health information may be used for such purposes.

I also recognize that it is my responsibility to arrange to have my or my child's previous medical records, if applicable, forwarded to DeVito Internal Medicine and Pediatrics, LLC.

Signature of Patient or Legal Representative

Print Legal Rep. Name (if applicable)

Date

Relationship to Patient (if applicable, please check one):

Parent or guardian of unemancipated minor _____

Court appointed guardian _____

Power of Attorney _____

II. Consent to Release Prescription History

I agree to allow DeVito Internal Medicine and Pediatrics, LLC to view my prescription history from external sources.

Signature of Patient or Legal Representative

Print Legal Rep. Name (if applicable)

Date

III. Designation of Certain Relatives, Close Friends and other caregivers

I agree that DeVito Internal Medicine and Pediatrics, LLC may disclose certain documents regarding my health information to a family member, close personal friend or other caregiver because such a person is involved with my health care.

I designate the person(s) listed below as the individual(s) involved with my health care provided by DeVito Internal Medicine and Pediatrics, LLC for the purpose of making the disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time by submitting a written request to DeVito Internal Medicine and Pediatrics, LLC.

Print Name: _____ Relationship: _____ Phone: _____

Print Name: _____ Relationship: _____ Phone: _____

Signature of Patient or Legal Representative

Print Legal Rep. Name (if applicable)

Date