LOURDES
HEALTH MANAGEMENT SERVICES ORGANIZATION

Patient Acknowledgement of Receipt of Lourdes Medical Associates Notice of Privacy Practices (HIPAA)

Patient Name (please print): _____

Patient Address (please print): _____

Physician Name (please print): _____

By signing below, I acknowledge that I have reviewed the Lourdes Medical Associates' Notice of Privacy Practices. This notice describes how medical information about me may be used and disclosed, and how I can get access to this information.

In addition, I give permission for this office to discuss my medical records with other doctor's offices, specialists, hospitals, and radiology facilities. I also give permission for the following person(s) to receive medical information on my behalf (please check one):

☐ No one else

☐	Print Name	Relationship	Date
☐	Print Name	Relationship	Date
☐	Print Name	Relationship	Date

Patient / Guardian Signature	If Guardian, state relationship to patient	Date

☐ 2013	☐ 2016	☐ 2019	☐ 2022	☐ 2025
☐ 2014	☐ 2017	☐ 2020	☐ 2023	☐ 2026
☐ 2015	☐ 2018	☐ 2021	☐ 2024	☐ 2027