COMPREHENSIVE COMMUNITY HEALTH CENTERS, INC.

Patient Name: _____ Date Of Birth: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT TO RELEASE PERSONAL HEALTH INFORMATION (PHI)

Effective January 1, 2016

I, the undersigned, hereby acknowledge that I have been provided with a copy of Comprehensive Community Health Centers, Inc.'s ("CCHC") Notice of Privacy Practices (the "Notice"), and have been given the opportunity to read the Notice prior to any service being provided to me by CCHC,. I further acknowledge that I have been informed that a copy of the current Notice of Privacy Practices is posted in the reception area. CCHC reserves the right to change the Notice of Privacy Policies. You may obtain a copy of the current Notice of Privacy Practices by requesting a copy.

By signing this form, I consent to the use and disclosure of my medical information for treatment, payment and healthcare operations. I understand that I have the right to revoke this consent in writing, signed by me. I acknowledge that such revocation, however, shall not affect any disclosures that have already made in reliance on my prior consent. CCHC provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH).

CCHC providers/staff may contact me in the following manner (check all that apply) to confirm appointments or to discuss lab results. :

CELLULAR TEL. NO.: _____
☐ YES, leave message on voicemail
☐ NO, do not leave message on voicemail

HOME TEL. NO.: _____
☐ YES, leave message on voicemail
☐ NO, do not leave message with a family member

TEXT MESSAGES to: _____
☐ YES, send me text messages. *Standard text message rates may apply. I acknowledge, agree and accept any and all costs charged to me by my cellular carrier as a result of receiving said text messages.*
☐ NO, do not text me.

EMAIL:
☐ YES, email to the following address: (please indicate full email address:i.eyouremail@domain.com)
_____
☐ NO, do not email me.

STANDARD MAIL:
☐ YES, send mail to my home address. (please indicate city, state and zip)
_____
☐ NO, do not send mail to my home address.

Signature of Patient/Legal Representative: _____

Date: _____ If Legal Representative, relationship to Patient: _____

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