

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 and/or staff may contact me via phone, text or mail to discuss test results, confirm appointments or to obtain referral information.

Signature of Patient/Legal Representative: _____

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