

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE
AND DISCLOSE HEALTH INFORMATION**

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorized Chalfont Family Practice to use and disclose health information about you for treatment, payment and health care operations purposes.

Notice of Privacy Practices. Chalfont Family Practice has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information (PHI) and how you can access your PHI and exercise other rights concerning your PHI. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all PHI that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our office.

Our address is: 65 E. Butler Ave.
Suite 201
New Britain, PA 18901
Telephone: 215-822-3113

Acknowledgement and Consent

I have received the Notice of Privacy Practices for Chalfont Family Practice. Chalfont Family Practice is authorized to use and disclose health information about _____
(patient's name) for treatment, payment and healthcare operations purposes consistent with its Privacy Practices.

Signature of Patient
(or patient's personal representative)

Date

Name of personal representative and relationship