

# Acknowledgment of Notice of Privacy Practices Medinet Clinic

This notice serves as acknowledgement that I have read, understand, and have received a copy of the Notice of Privacy Practices for Medinet Clinic.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Date

## Authorization of Disclosure of Protected Health Information

I authorize Medinet Clinic to disclose my protected health information (PHI) to my family member(s) and/or friend(s) for the purpose of information, treatment and health care.

I understand that this authorization is valid until the time if and when it is revoked in writing.

Yes      Name of Person Authorized for disclosure of my Protected Health Information

\_\_\_\_\_  
Relationship to patient

No

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Witness \_\_\_\_\_