ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I was offered/provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read, if I chose) and understand the notice.

***Patient Name:_____ Date:_____**
***Signature: _____**
(Parent or Authorized Representative If Applicable)

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HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION CONCERNING ALL PRESCRIPTION/PHARMACY RECORDS

I understand and give consent to Dr. Edward S. Orman and or his medical staff to fully view all Prescription/Pharmacy information via Electronic Medical Records.

***Patient Name:_____ Date:_____**
***Signature: _____**
(Parent or Authorized Representative If Applicable)

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ADVANCED CARE PLAN OR SURROGATE DECISION MAKER

Do You have an Advanced Care Plan? Yes_____ No_____
Or
Surrogate Decision Maker:
Name: _____ Relationship:_____

***Patient Name: _____ Date: _____**
***Signature: _____**