



Drs. Love  
& Miller, P.C.

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## Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices for the offices of Drs. Love and Miller, PC. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of office's health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility.

Drs. Love and Miller, PC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY		
In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.		
Any member of my immediate family	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Spouse only	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other (please specify)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority