CAPITAL MEDICAL ASSOCIATES, P.C.

ACKNOWLEDGMENT OF PRACTICE PRIVACY NOTICE & CONSENT FOR RELEASE OF INFORMATION

I acknowledge receipt of Capital Medical Associates, P.C.'s Practice Information Packet detailing Office Procedures, Financial Policies, Patient Rights & Responsibilities, and Understanding Your Insurance Coverage. I acknowledge receipt of Capital Medical Associates Privacy Notice.

I am aware that my "Protected Health Information" (PHI) will be disclosed to those involved in my care and treatment, to insurance company (ies) and business associates of the Practice, for the purposes of carrying out treatment, payment or health care operations.

I understand that further authorization (s) may be necessary, as required by law, should additional disclosures of my PHI be requested. I may request further review of the privacy notification statements, at any time, prior to consenting to any disclosure of my PHI.

In addition, I give my permission to my physician and his/her staff to discuss my medical care and/or billing issues with the following. Unless otherwise indicated, this authorization is valid until revoked in writing by me or my legal representative.

Family & Other Care Providers that you authorize us to speak to or contact on your behalf:

My husband / wife / other and family (please list):

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Printed Patient Name

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Patient Signature