

**ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES
AND CONSENT FORM**

**Dr Ira S. Tucker and Associates
570 New Waverly Pl. Ste. 110
Cary, N.C. 27518
919-858-7555
Fax: 919-858-8455**

**Acknowledgement of Receipt of Privacy Policy and
Consent to use or disclose health information for treatment, payment and health care operations.**

Patient Name: _____

Patient Number: _____ Patient Phone Number: _____

Patient Address: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

When you sign this document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this acknowledgement and consent and understand it. I acknowledge that I have received a copy of the *Notice of Privacy Policies* from Dr. Ira S. Tucker and Associates and consent to the use and disclosure of my health information for purposes and in the methods described in that Notice.

Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient Print Name

Source of Authority: _____