Maple Street Clinic

Acknowledgment of Notice of Privacy Practices

My signature below indicates that I have been given an opportunity to read the Notice Of Privacy Practices for the **Macoupin County Public Health Department**, and to have any questions answered before signing.

Signed: _____ Date: _____

Printed Name: _____

If signed by someone other than the patient, please indicate relationship to patient:

( ) Parent or guardian of minor patient

( ) Guardian or conservator of an incompetent patient

( ) Beneficiary or personal representative of deceased patient

Consent to Release Information to Designated Family Member or Caregiver

The names listed below are allowed to have information released to them from Macoupin County Public Health Department with the undersigned consent.

_____ _____
Name to receive information and relationship Type of information **not** to release

_____ _____
Name to receive information and relationship Type of information **not** to release

_____ _____
Name to receive information and relationship Type of information **not** to release

This consent remains in effect for one (1) year period and will be updated and signed on a yearly basis or as needed per patient request. This consent may be revoked at any time upon written request.

FOR OFFICE USE ONLY:

Employee Signature: _____ Date: _____

If patient or patient's representative refuses to sign this Acknowledgment:

( ) Efforts to Obtain: _____

( ) Reason patient refused to sign: _____