

**PATIENT PRIVACY ACKNOWLEDGMENT FOR
FAMILY HEALTH CARE OF POST FALLS**

Our practice is committed to securing the privacy of your protected health information. Accordingly, the Notice of Privacy Practices is available to you upon your request. You are not required to read this Notice. However, we would like your acknowledgment that you have been notified that the practice has such a Notice of Privacy Practices.

I hereby authorize Family Health Care of Post Falls to release my medical information (i.e. test results, appointment times, etc.) to the following people:

Name Relationship

Name Relationship

Name Relationship

Name Relationship

Family Health Care of Post Falls has my permission to leave messages containing medical information or the name of medical provider at the contact numbers provided in the patient information/profile. Yes No Initials_____

Printed Name

Signature

Date