Jewish Physician Group
KentuckyOne Health™

Notice Of Privacy Practices For Protected Health Information Acknowledgement Of Receipt Of Notice Of Privacy Practices

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I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Patient Name: _____

Patient Signature:_____

Date_____

Can we leave a message on: Cell phone: _____

Home phone: _____ Work phone: _____

Please list the names of anyone that you personally authorize to receive your health information.

_____ _____

_____ _____

_____ _____

_____

Signature Date