PONTE VEDRA CONCIERGE MEDICINE

KNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBER OR OTHER THIRD PARTY

I authorize the Practice to release my medical and /or billing information to the following individual(s):

Name (1)

Relationship to Patient:

Name (2)

Relationship to Patient:

Name (3)

Relationship to Patient

I hereby authorize the disclosure of my individually identifiable health information to the individual(s) listed above. I understand that this authorization is voluntary. I further understand that if the party authorized to receive the information is not a health plan or health care provider; the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release the Practice from all liability arising from this disclosure of my health information. I am aware that such records may contain information related to mental health, substance abuse (both alcohol and drug) and sexually transmissible diseases (including tests results related to HIV/AIDS), and I specifically authorize the release of such information pursuant to this authorization.

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Signature Printed Name DOB Date