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## The Reading Hospital Medical Group

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**THE READING HOSPITAL MEDICAL GROUP**  
**HEALTH CARE INSURANCE PORTABILITY & ACCOUNTABILITY ACT**  
**(HIPAA)**  
**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY**  
**PRACTICES**

**CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION  
FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS**

I, the undersigned, understand that as part of my health care, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and services provided information to my bill
- A means by which a third party payer can verify that services were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notices and practices and prior to implementation, will mail a copy of any revision notice to the address that I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

**By signing on the reverse side of this document, I acknowledge that I have been given a copy of or viewed the posted Notice of Privacy Practices for The Reading Hospital Medical Group. I understand that I have the right to refuse to sign this acknowledgement.**

Please complete back side of this form

I wish to have the following **restriction** to use or disclose my health information:

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I **authorize** the disclosure of my Personal Health Information to the following individuals:

**My spouse**

Spouse's Name and Phone Number:

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**Family members**

Specify Name, Relationship, and Phone Number:

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**Caregivers**

Specify Name, Relationship, and Phone Number:

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**Other**

Specify Name, Relationship, and Phone Number:

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I wish to be contacted in the following manner.

Please check all that apply:

**Home Telephone**

- You have my permission to leave a message with detailed information.
- Leave a message with a call-back number only.

**Work Telephone**

- You have my permission to leave a message with detailed information.
- Leave a message with a call-back number only.

**Written Communication**

- You have my permission to send mail to my home address.
- You have my permission to send mail to my work/office.

I fully understand and accept/decline (please circle) the terms of the consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name Printed \_\_\_\_\_

Parent Sign Here if Patient is a Minor: \_\_\_\_\_ Date: \_\_\_\_\_

**Office Use Only**

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- Emergency situation prevented us from obtaining acknowledgement
- Other \_\_\_\_\_