____ _______________

Print patient name Date of birth

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE OF
FAMILY FIRST HEALTH

This form is an acknowledgment of the receipt of the Notice of Privacy Practices of Family First Health.

I acknowledge that I have received a copy of the Notice of Privacy Practices ("Notice") of Family First Health.

I acknowledge that I received a copy of this Notice at the time I received services from the Provider.

If I have questions regarding the Notice, I may contact the Provider and ask for the Privacy Official **located at 116 South George Street, Suite 301, York, PA 17401 or by calling (717) 801-4806.**

1. My individually identifiable health information may be used and disclosed to carry out treatment, payment, or health care operations

a. **I give permission for Family First Health to release protected health information (PHI) to the following individuals.**

______________________________ _________________________
Name Relationship

______________________________ _________________________
Name Relationship

2. The Notice of Privacy Practices provides a more complete description of the types of uses and disclosures. I have the right to request a copy of the Notice from the Provider.

3. The terms of the Notice may change at any time. If the Notice is changed, I may contact the Privacy Official identified above to request a Notice.

Signature of patient or patient's representative: ______________________________ Date: ___________

Printed name of patient's representative: ______________________________________

Relationship to the patient: ____Parent ___ Legal Guardian ___ Power of Attorney

Family First Health will retain this "Notice" and "Acknowledgment" for six (6) years from the signature date on this form.