
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.