www.riversidediabetes.com
riverside.diabetes@gmail.com

Patient Acknowledgment Form

Use & Disclosure of Protected Health Information

Riverside Medical Associates, P.A. “Notice of Privacy Practices” provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office’s Notice of Privacy Practices by initialing below:

Patient’s Initials

Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, this office will post changes in our waiting room area. You will receive a revised copy at your scheduled appointment date.

Patient’s Initials

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment , payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

Patient’s Initials

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent , in writing, except where we have already made disclosures in trust of your prior consent.

www.riversidediabetes.com
riverside.diabetes@gmail.com

Signature Date