

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE  
MEDICAL RECORDS CONSENT  
PRESCRIPTION MEDICATION REQUEST CONSENT**

**I acknowledge that I have received the Privacy Notice.**

\_\_\_\_\_  
Patient or Personal Representative Signature

\_\_\_\_\_  
Date

**I agree that my prescription medication history may be requested from other healthcare providers or third party pharmacy benefit payors and used for treatment purposes.**

\_\_\_\_\_  
Patient or Personal Representative Signature

\_\_\_\_\_  
Date

**If you would like us to discuss your care or medical records with someone, other than yourself, your parents (if a minor) or your legal guardian, please list their name(s) below:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

**If Personal Representative's signature appears above, please describe Personal Representative's relationship to patient:**

\_\_\_\_\_