Drs. Judd & Mengert
Notice of Privacy Policies

Last Name: First Name:

Date of Birth:

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY POLICIES AND PROCEDURES

We keep a record of the healthcare services that we provide you. You may ask to see and receive a copy of that record at any time. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record, or get a detailed copy of our privacy practices by request.

By my signature below I acknowledge receipt and understanding of Privacy Practices.

_____ Date:
Patient or legally authorized individual signature

_____ _____
Printed name if signed on behalf of patient Relationship

I, _____ hereby authorize Drs. Judd and Mengert to discuss the following information: Appointment information, Treatment information, and Billing/Insurance information with the following individuals:

1._____ _____ _____
Name of the individual Relationship to patient Phone number

2._____ _____ _____
Name of the individual Relationship to patient Phone Number

IF YOU WOULD LIKE A COPY OF OUR NOTICE OF PRIVACY PRACTICES, PLEASE NOTIFY A MEMBER OF OUR STAFF.