Lifepoint Health
LAS CRUCES PHYSICIAN PRACTICES, LLC

HIPAA ACKNOWLEDGEMENT

In this Acknowledgement, "Patient" means the person receiving treatment. "Legal Representative" means the person acting on behalf of the Patient and signing as the Patient's representative (if this Acknowledgement is not signed by the Patient themselves). The words, "I", "you" and "me" may in context include both the Patient and/or the Legal Representative. The words "my" refer to the Patient.

I give permission for the Clinic to disclose my PHI for purposes of communicating results, findings, and care decisions to the individuals listed below. This consent will remain in effect until I notify the Clinic in writing that I want to revoke it or until I sign another consent addressing the same types of disclosures. Please note that this does not allow these individuals to obtain copies of my full medical record without a complete and valid authorization from me or as otherwise permitted by law.

NAME	RELATIONSHIP	CONTACT NUMBER

I have read and fully understand this HIPAA Acknowledgement and been given the opportunity to ask questions. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

_____
Printed Name of Patient

_____ _____
Signature of Patient or Legal Representative for Health Care Services if Other Than Patient — Date and Time

_____
Relationship to Patient

_____
Reason Individual is Unable to Sign, i.e., Minor or Legally Incompetent

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