Hilltown Community Health Center

Acknowledgment and Release of Information Form

Print Patient Legal Name:______________________________________ Date of Birth:______________

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

By checking the following box and signing the bottom of this form, I acknowledge that I have received a copy of the Hilltown Community Health Centers, Inc. Notice of Privacy Practices by going to www.hchcweb.org.

☐ Received/Reviewed Notice of Privacy Practices

NOTICE OF PATIENTS RIGHTS ACKNOWLEDGMENT

By checking the following box and signing the bottom of this form, I acknowledge that I have received a copy of the Hilltown Community Health Centers, Inc. Notice of Patients Rights by going to www.hchcweb.org.

☐ Received/Reviewed Notice of Patients Rights

RELEASE OF INFORMATION

I HEAREBY AUTHORIZE THE STAFF OF THE Hilltown Community Health Centers, Inc. to render such services as may be deemed necessary to me. I also authorize the release of all NECESSARY information to insurance companies, other payers, and medical providers. I assign the Hilltown Community Health Centers, Inc. authority to claim and collect medical insurance on my behalf.

If the insurance information we have is incorrect, and your visit is **NOT** covered by your insurance, **you will be responsible for payment of this visit.**

PATIENT SIGNATURE: ____________________________________ Date: _____________________

(If patient is under 18 years of age, parent or guardian must sign)

If signed by other than patient, print name and relationship to patient

____

Signee Name **Relation to patient**