ACKNOWLEDGEMENT OF RECEIPT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You May Refuse to Sign This Acknowledgement)

I, ________________________________(print), have received a copy the Notice of Privacy Practices of Level Up Anesthesia.

____ ________________________

Signature of Patient or Guardian Date

ELECTRONIC COMMUNICATIONS PRIVACY WAIVER

I understand that my medical records may be transmitted electronically by fax or email and may be received in error by a third party. In the event that this should occur, I absolve Level Up Anesthesia of all liability. I give my consent to fax or email my medical records for the purposes of treatment, payment, or healthcare options and I understand that I may withdraw in writing this consent at any time.

____ ________________________ Signature

Patient or Guardian (print) Date

PATIENT AUTHORIZATION FOR ACCESS TO PROTECT HEALTH INFORMATION

I give permission for the following people to have access to my Protected Health Information and reserve the right to revoke this at any time by notifying in writing Houston Anesthesia Consultants' office.

___ Any family member

___ Specific family member

___ Other (friend, caregiver)

Name(s)/Relationship

1. ____
2. ____
3. ____

Signature: ____ Date:______________________

Printed Name: ____

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