



Acknowledgement of Receipt of Notice of Privacy Practices

Blue Ridge Healthcare is providing you a copy of our Notices of Privacy Practices. The notice provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices. By signing this form, you agree that you have had the opportunity to read our Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices for Blue Ridge Healthcare.

Name (Please Print): _____

Signature of patient (or representative)

___/___/___
Date

Request to Release Information

I hereby authorize Blue Ridge Healthcare to release any information about myself and my account to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Request for Treatment

This facility maintains personnel and facilities to provide medical care to me. I authorize this facility's personnel to perform or provide the care ordered by my physician(s) of the nature and purpose of any proposed operation or procedure and any available alternative methods of treatment, together with an explanation of the risks associated with each of them. This form is not a substitute for such explanations, which are the responsibility of my physician(s) to provide me according to recognized standards of medical practice. I choose to receive the service(s) even if my insurance plan may not cover or continue to cover specific service(s) including the specific services(s) rendered during this visit.

Patient Signature: _____ Date: _____

Responsible Party (ies): _____ Date: _____

Relationship to Patient: _____ Self _____ Spouse _____ Parent _____ Other

Witness: _____ Date: _____