Bryn Mawr Medical Specialists Association
933 Haverford Road
Bryn Mawr, PA 19010
(610) 527-3800 ext 265

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND CONSENT TO USE HEALTH INFORMATION

Read before signing the Acknowledgment and Consent

This acknowledgment of notice and consent authorizes Bryn Mawr Medical Specialists Association to use health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices Bryn Mawr Medical Specialists Association has a Notice of Privacy Practices, which describes how we may use your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent.

http://www.bmmsa.com/images/forms/bmmsa-noticeofprivacy.pdf

If you'd like to receive a personal copy of the Privacy Notice, please request one at the time of your appointment.

Amendments We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer:

Mail: Bryn Mawr Medical Specialists Association
933 Haverford Road
Bryn Mawr, PA 19010
Attn: Russ Militello Telephone: (610) 527-3800 ext 265

Acknowledgment and Consent

I have received the Notice of Privacy Practices for Bryn Mawr Medical Specialists Association. Bryn Mawr Medical Specialists Association is authorized to use health information about (please print patient's name) ____ for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

____

Signature of Patient Date **Acct#**

Personal representative information (if applicable):

____ ________________________________

Name of Personal Representative Relationship to Patient

Please provide us with your contact information and the name or other specific identification of the person(s) or class of persons to whom the covered entity may disclose the covered information:

_____ I prefer to be contacted by my physician / physician's office at the following phone # (s) *(Please circle the best day time phone #)*

Home: _________________ Cell: _______________ Other: ________________

Do we have permission to leave a message? ❑ Yes ❑ No

_____ You have permission to speak with the designated / authorized person(s) named:

____

_____ You have permission to contact me via email at the following email address:

____

Revised: 6/27/2011