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

Read before signing the Acknowledgement & Consent

This acknowledgement 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 (revised 8/2013): 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. Please review our current notice prior to signing this acknowledgement and consent.

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

If you would like to receive an additional 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
825 Old Lancaster Road, Suite 320
Bryn Mawr, PA 19010
Attention: Russ Militello

Telephone: (610) 527-3800, ext. 3027

Acknowledgement & 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 (print 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 number(s) (Please circle the best daytime phone number)

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 e-mail at the following e-mail address:

_____