ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE & CONSENT TO USE HEALTH INFORMATION
Read before signing the Acknowledgement and 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 only.

Notice of Privacy Practices (revised 10/2024): 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.

https://bmmsa.com/wp-content/uploads/2024/12/BMMSA-HIPAA.NoticeOfPrivacyPractices12132024.pdf

If you would like to receive a paper 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.

Mail:	Bryn Mawr Medical Specialists Association
	825 Old Lancaster Road, Suite 320
	Bryn Mawr, PA 19010
	Attention: Salvatore Filippello
Phone:	(610) 527-3800, extension 4177

Acknowledgement & Consent

I have received the notice of Privacy Practices for Bryn Mawr Medical Specialists Association. Bryn Mawr Medical Specialist Association is authorized to use health information regarding _____ (***Print Name***) for treatment, payment, and healthcare operation purposes consistent with its Notice of Privacy Practices.

_____
Signature of Patient or Representative   Date of Birth   Date   Account #

Relationship to Patient (if applicable): _____

Release of Covered Information

Please **CIRCLE** your preferred phone number

Home: _____   _____ Office may leave **message with detailed information.**

Mobile: _____   _____ Office may leave **message with callback number/name only.**

Email Address: _____

I give permission to disclose personal health information to (**please circle**):

Spouse   Adult Children   Parents   Siblings   Personal Representative

List names and phone numbers of above:

_____

Rev: 7/2/2025