ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge receipt of the Privacy Practice of Dr. Antonio Zárate and acknowledge that I have had the opportunity to read this description of their privacy practices and ask questions regarding their privacy practice.

Dated:

_____ _____

Signature of Patient/ Parent/ Guardian

_____

Print Patient's Name

The patient, _____, was provided a copy of this Acknowledgement of Receipt of Privacy Practices and has either been unable to sign, or has refused to sign it.

Dated:

_____ _____

Privacy Officer/Contact Person

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Having read and understood the Privacy Practice of Dr. Antonio Zárate, I hereby consent to the use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

I understand that I am not required to give this consent in order for Dr. Antonio Zárate to use my protected health information for treatment, payment activities and health care operations. I also understand that I may revoke this consent in writing by submitting the revocation to the Privacy Officer/Contact Person listed in Dr. Antonio Zárate's Privacy Practices notice. I further understand that if I decline to give my consent or if I revoke it, Dr. Antonio Zárate may refuse to treat me or proceed with treatment, payment activities and health care activities as if consent was given or not revoked.

Dated:

_____ _____

Signature of Patient/ Parent/ Guardian

_____

Print Patient's Name

The patient, _____, was provided a copy of this Consent to Use and Disclose Protected Health Information and has either been unable to sign or refused to sign it.

Dated:

_____ _____

Privacy Officer/Contact Person

REVOCATION OF CONSENT

I hereby revoke the consent for Dr. Antonio Zárate to use my protected health information which I gave on ____/____/_____. I understand that Dr. Antonio Zárate may refuse to treat me or may proceed with treatment payment activities and health care operations as if this revocation was not made.

Dated:

_____ _____

Signature of Patient

Note: Keep copy of this document in patient's chart and office HIPAA file.