Bailey Health LLC
Patient Acknowledgement and Authorization

Effective: 5/01/2024

By signing this document, you acknowledge that you have received, read, and understand the Bailey Health Privacy Notice. You also authorize Bailey Health LLC to use and disclose your health information as described in the Privacy Notice and as permitted by law.

Acknowledgement

I acknowledge that I have received a copy of the Bailey Health LLC Privacy Notice. I understand that Bailey Health LLC may use and disclose my health information for treatment, payment, and healthcare operations as outlined in the notice.

Authorization

I authorize Bailey Health LLC to use and disclose my protected health information for the purposes of providing medical treatment, receiving payment, and carrying out healthcare operations. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken based on my authorization.

Patient Rights

I understand that I have the right to:

- Request restrictions on certain uses and disclosures of my health information.
- Request confidential communications.
- Access and request amendments to my health information.
- Receive an accounting of disclosures of my health information.

Consent

I consent to Bailey Health LLC discussing any or all of my personal Medical Information, including my evaluation, treatment, diagnosis, even if related to psychiatric or psychosocial impairment, substance abuse, acquired immunodeficiency virus (HIV), HIV-related opportunistic infection, or pregnancy, with the following person(s).

	Name	Relationship	Phone #	Address
1.)				
2.)				
4)				
5.)				

To better provide for your care and enhance your patient experience, we seek to coordinate and integrate our care delivery through our electronic medical records (EMR) which is paperless. We share access to the EMR across our practice locations (accessed only as described in the Notice of Privacy Practices).

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Bailey Health LLC. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signature

Patient Name: _____
Patient Signature: _____ **Date:** _____
Parent/Guardian (if applicable): _____ **Date:** _____
Witness: _____ **Date:** _____

If not signed by the patient, please indicate your relationship to the patient: _____

For Office Use Only:

☐ Signed form received by: _____

☐ Acknowledgement refused: _____

☐ Efforts to obtain: _____

Reason for refusal: _____