



### **Acknowledgement of Receipt of The Privacy Practices**

The privacy practice is/was provided so that I can make an informed decision whether to allow release of the information.

I understand that I do not have to sign this authorization in order to receive treatment from Platte County Wellness Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Platte County Wellness Center  
1305 Plaza Ct  
Platte City, MO 63079

Signed by:

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient's Legal Guardian (if applicable)

I authorize the staff at Platte County Wellness Center to release health information to the following individual(s) or medical practice(s):

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Medical Practice Name/Provider Name

\_\_\_\_\_  
Fax Number