PATIENT ACKNOWLEDGMENT AND CONSENT

For New Patients Only

I have been given a copy of Dayspring Family Medicine Associates, PLLC's, Notice of Privacy Practices, version effective _____. I consent to the uses and disclosures of my health information as outlined in the Notice.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

_____

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of Patient: _____

_____

_____

FOR DAYSPRING FAMILY MEDICINE ASSOCIATES USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

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