



CYNTHIA DESMOND, ARNP  
LAURAL SCHABERG, ARNP

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### **PRIVACY PRACTICES ACKNOWLEDGEMENT**

**Please Read The Following Statements Carefully**

A copy of our Notice of Privacy Practices will be provided for your review upon request. By signing this form you consent to the use and disclosure of your protected health information necessary to carry out treatment, payment activities and general healthcare operations.

**You have the right to revoke this consent** at any time by giving us written notice of your revocation submitted to this office as listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue to treat you if you revoke this consent.

**Please check how we may communicate regarding health information or appointment reminders.**

I wish to be contacted in the following manner (check all that applies):

Home Telephone	Written Communication
<input type="checkbox"/> Leave message with detailed information	<input type="checkbox"/> mail to home address
<input type="checkbox"/> Leave message with callback number only	<input type="checkbox"/> Fax to this number _____

May we contact you at work?      Yes       No

Work telephone number	Cell Phone
<input type="checkbox"/> Leave message with detailed information	<input type="checkbox"/> Leave message with detailed information
<input type="checkbox"/> Leave message with callback number only	<input type="checkbox"/> Leave message with callback number only

I hereby give permission to Desmond, Schaberg, ARNPs PNWPC to disclose information regarding treatment to: **(please list by name & relationship)**

Spouse/Partner \_\_\_\_\_ Son/Daughter \_\_\_\_\_

Others \_\_\_\_\_

**I hereby acknowledge receipt of the Notice of Privacy Practices and have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy practices. I understand that, by signing this consent form. I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations**

NAME (printed) \_\_\_\_\_ Birth date \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_