Elizabethtown Community Hospital

Patient acknowledgement of

Notice of Privacy Practices

The hospital's Notice of Privacy Practices provides information on how it may use and disclose your protected health information. ECH is required by law to provide you with a notice and obtain your acknowledgement of having received it.

____ ____________________

SIGNED (PATIENT) DATE

____

SIGNED (ON BEHALF OF PATIENT) Relationship to patient

Employee use only:

If unable to get acknowledgement please describe reason below and sign (ex: patient unresponsive):

____
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Employee Signature

____

Date

Form to be placed in medical record chart.

Elizabethtown Community Health Center

Patient Information

Patient Name____ Date of Birth________________

SS#__________________________Marital Status_ ______________Sex(M or F)_____Race__________

Ethnicity____

Mailing Address____

City______________________________County_________________State________ Zip Code_________

Alternate Address____

City______________________________County_________________State_________Zip Code________

Telephone (Home)_____________________ Work__________________ Cell____________________

Email Address____

Pharmacy Name_______________________________________ Pharmacy Telephone________________

Employer____

Employer Address____

City______________________________County_________________State__________Zip Code________

Emergency Contact____Telephone____________________

Parent or Spouse Name____ Date of Birth____________

SS#_________________ Employer________________________ Employer's Telephone______________

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I, ______________________________, date of birth ________________, give permission for the staff of The Elizabethtown Community Health Center to discuss and exchange information regarding my treatment and condition with ____ until further notice, or for the period from ________________________ to __________________.

Patient/Parent Signature ____________________________________ Date ________________________

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I hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents to governmental agencies, insurance carriers, or others who are financially liable for my medical care and to permit representative thereof to examine and make copies of all records relating to such care and treatment. I hereby authorize and direct that all benefits payable for the benefit of myself and /or dependents be paid directly to the provider of service. Patient agrees to sign any additional assignment of benefits forms requested by the provider or insurance company. Patient or guardian understands that he/she is liable to Elizabethtown Community for all related charges, whether or not covered by insurance.

Signed____ Date ____________________________________

(State relationship to minor patient or representative) Witness ____________________________________