

**CAPITOL MEDICAL GROUP**

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**PATIENT ACKNOWLEDGEMENT/CONSENT FORM**  
**Use and Disclosure of Protected Health Information**

Capitol Medical Group’s “Notice of Privacy Practices” provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office’s Notice of Privacy Practices by initialing below:

\_\_\_\_\_  
Parent/Patient/Guarantor initials

Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, you will receive a revised notice on your next visit to the office.

\_\_\_\_\_  
Parent/Patient/Guarantor initials

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

\_\_\_\_\_  
Parent/Patient/Guarantor initials

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to \_\_\_\_\_ for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plans as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

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Signature

Date

*Please return this completed form to the receptionist.*

**Names and birthdays of all family members in this practice:**

_____	_____	_____
_____	_____	_____