Ahead to Health, LLC

HIPAA
Acknowledgement & Consents
Authorization

I acknowledge that I have received a copy of the Ahead to Health, LLC Notice of Privacy Practices and have been given an opportunity to review and understand it. The notice describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of health care operations. The notice also describes my rights and the duties of Ahead to Health, LLC with respect to my protected health information.

X _____ Date_____
Patient or Representative Signature

I **consent** to allowing Ahead to Health, LLC to use and or disclose my Protected Health Information in compliance with their policies as indicated in their Notice of Patient Privacy Practices.

Print Patient Name:_____

Print Name of Personal Representative (if applicable): _____

X _____ Date:_____
Patient or Representative Signature

I give permission for my personal health information TO BE RELEASED to my immediate family (spouse, children, and/or parents) upon their request.

X_____ Date:_____
Patient or Representative Signature