



Privacy Notice Acknowledgement Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 I have specific rights to privacy of my personal health information.

I understand that North Coast Professional Company, LLC dba Firelands Physician Group may disclose my personal health information for treatment, payment, and the office's health care operations.

I have had the opportunity to receive a copy of the Notice of Privacy Practices and understand my rights and responsibilities as outlined in the notice.

I understand that North Coast Professional Company, LLC dba Firelands Physician Group may contact me regarding treatment and services and that the office will accommodate reasonable requests as to how I will receive such information. I understand that the contacts I provide to the staff may be contacted and will receive my personal health information. I understand that if I wish to remove a contact, I can submit a request to the staff of North Coast Professional Company, LLC dba Firelands Physician Group.

I authorize that I have read, understand, and give my consent to the above:

Patient or Responsible Party Name

Patient or Responsible Party Signature

Date