



MRN# _____

DOB _____

***Receipt of Notice of Privacy Practices Written
Acknowledgment & Consent Form***

I, _____, have been offered a copy of Calvert Sleep Center Notice of Privacy Practices. I have been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this Notice, and how I may obtain access to and control of this information.

By signing, below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates.

Signature of Patient/Parent or Guardian: _____

Description of Personal Representative's Authority: _____

Date: _____

Effective Date 12/01/2017

410-414-6185

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