**Acknowledgment of Receipt of Notice**

**Cancellation & Prescription Policy**

*I acknowledge that I have had the opportunity to review a copy of NEFEDA’s Cancellation and Prescription Policies. By signing below, you agree and understand the terms and conditions stated within these policies.*

*Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**For Use and Disclosure of Protected Health Information**

*By signing this form, I consent to the use and disclosure of my PHI to carry out treatment, payment and health care operations (TPO). This consent may be revoked by submitting a request in writing. If I decline to sign this consent, this practice may decline to provide treatment.*

*Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Obtaining External Rx History**

*I give my full permission to Northeast Florida Endocrine & Diabetes Associates to retrieve my external Rx history from my pharmacy.*

*Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Laboratory & Financial Policy**

*I acknowledge that I have reviewed a copy of the Laboratory and Financial Policies. By signing below, you agree and understand the terms and conditions stated within these policies.*

*Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**HIPAA**

*I acknowledge that I have had the opportunity to review a copy of NEFEDA’s Notice of Privacy Practices ("Notice"). I understand that I am responsible to read this Notice and notify NEFEDA, in writing, of any request for restrictions in the use or disclosure of my PHI. I understand NEFEDA has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location at all times and on their website at: www.nefeda.com. NEFEDA will provide me with a copy of its most recent Notice upon my request.*

*Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Consent for Medical Information Release**

*There are times we are asked to give family members or others information regarding you and your treatment. If you would like for us to give out information, please fill in the name of the individual and their relationship to you. Please designate which type of information each person may receive by circling the items we may release.*

*Name(s) of others authorized to discuss or request medical information:*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Circle: All info Appointments only STD’s/HIV***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Circle: All info Appointments only STD’s/HIV***

*If you would like to view our HIPAA, visit:* [*https://nefeda.com/wp-content/uploads/2019/10/HIPAA-Form.pdf-file-2.pdf*](https://nefeda.com/wp-content/uploads/2019/10/HIPAA-Form.pdf-file-2.pdf)

*If you would like to view our Consents/Policies, visit:* [*https://nefeda.com/wp-content/uploads/2019/10/PatientPolicy\_NEW.pdf-file-3.pdf*](https://nefeda.com/wp-content/uploads/2019/10/PatientPolicy_NEW.pdf-file-3.pdf)