

JASON H. FROST, D.O., P.A.

601 N. Flamingo Road, Suite 319
Pembroke Pines, Florida 33028

Patient Acknowledgement of Receipt of the Notice of Privacy Practices and Consent to Use and Disclose Health Information

I acknowledge that I was provided with a copy of the Jason H. Frost, D.O., P.A.'s Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. Provided that Jason H. Frost, D.O., P.A. continues to its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my Health Information for the purposes and the activities permitted under the federal privacy law.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling Jason H. Frost, D.O., P.A. at 954/442-8786.

I acknowledge that I have received a copy of the Jason H. Frost, D.O., P.A. Notice of Privacy Practices.

Patient Name

Date

Signature of Patient

Patient Legal Representative(if applicable)

Date

Signature of Legal Representative

FOR PHYSICIAN'S OFFICE USE ONLY

Office Staff Member Obtaining Signature

Reason Signature was not obtained:

- Individual Refused to Sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other(please specify)
