

**Bureau for Behavioral Health and Health Facilities (BHFF)**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
AND CONSENT TO USE AND DISCLOSE FOR TREATMENT, PAYMENT AND  
HEALTH OPERATIONS PURPOSES**

**PATIENT**

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

Date of Birth: \_\_\_\_\_ ID Number: \_\_\_\_\_

I hereby consent for Sharpe Hospital to use and disclose my protected health information for treatment, payment and health care operations purposes. These purposes are described, and examples of each purpose are given, in Sharpe Hospital's attached Notice of Privacy Rights. This also acknowledges that I have received a copy of the Sharpe Hospital Notice of Privacy Practices. This consent does not apply to protected health information for psychotherapy notes and marketing purposes, where an authorization is required under 45 CFR § 164.508. I retain the right to request restrictions on how and to whom the protected health information may be released, although Sharpe Hospital does not have to accept my restrictions.

A person or organization that receives my information because of this consent may have the legal right to disclose this information to other people or organizations without my knowledge or consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

If this authorization is signed by someone who is not the patient/resident listed at the top of this form, provide a description of the signer's authority to act for the patient.

Type of authority: \_\_\_\_\_

Documentation Provided \_\_\_\_\_ yes \_\_\_\_\_ no

Disposition: To be filed in the patient's medical record. May also be filed with the Privacy Official.