CLARKE PHYSICIANS

P: (281) 481-9299
F: (281) 481-9286

OKLAHOMA
4415 S. Harvard Avenue
Tulsa, OK 74135

TEXAS
1414 S. Friendswood Drive Ste. 430
Friendswood, TX 77546

Patient Acknowledgement of Disclosure of Protected Health Information

Patient's Name: ________________________________ Date: _______________________

I, the undersigned, do agree the above referenced office may contact me regarding any information necessary in the operation of the clinic. This includes, but is not limited to, patient follow-ups, appointments, medical reports and information that the doctor or staff deems necessary in providing healthcare services to you.

In accordance with the Federal Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security, Section 164.520 (c)(2)(i) and Section 164.520 (c)(2)(ii), I have received written notice of this office's privacy compliance.

My signature on this letter is written acknowledgement of notification of receipt.

_____________________________________ ___________________________

Signature of patient (or guardian) Date of signature

*A copy of this notification is given to you (upon request) and the original will be kept in your medical file.

Acknowledgement of this signature is verified and witnessed by:

__________________________________ _____________________________

Privacy Officer Date of signature