Patient Acknowledgement of HIPAA Privacy Practice

Patient Name: _____

Date of Birth: _____

A&M Phlebotomy Service, LLC will maintain a record of your service visits solely for the purpose of coordinating care with my medical provider and obtaining payment for the services rendered. I provided A&M Phlebotomy Service, LLC consent to act on my behalf with respect to the transmission of my information for the stated purpose. If I would like to revoke this consent at anytime I will provide A&M Phlebotomy Service, LLC with written notice.

I understand that I am contracting A&M Phlebotomy to obtain my samples and my information for the purpose of diagnosis, treatment, and payment when necessary. By signing this form, I am acknowledging that I have received a signed copy of this HIPAA consent form for my documentation and record keeping. Prior to signing, I had an opportunity to read, review, and ask questions about the intent of this form.

Signature: _____

Date: _____

Relationship to Patient (If signed by representative of the patient):

_____

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