

**650 Fulton Street**

**Brooklyn, NY 11217**

**(P) 718-596-9800**

**NOTICE OF PRIVACY ACKNOWLEDGEMENT / CONSENT FORM**

**I**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the undersigned patient or other person legally authorized to act for the patient, have been provided with a copy of the Notice of Privacy Practices for Protected Health Information, and I have had the right to review the Notice prior to signing this Consent.

**Consent for Use and Disclosure of Protected Health Information:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the undersigned patient or other person legally authorized to act for the patient, understand and agree that all health information concerning the above - named patient, “Protected Health Information” (PHI) shall remain the property of Brooklyn Plaza Medical Center, Inc. (BPMC). I consent to the use and disclosure of such PHI in BPMC’s Notice of Privacy Practices. Except for the reasons described in the Notice, I may revoke this Consent in writing at any time using the procedure outlined in the Notice.

This is to certify that I, the undersigned patient or other person legally authorized to act for the patient have read this Consent for Use and Disclosure of Protected Health Information and acknowledgement of Receipt of Notice of Privacy Practices, understand its content, and accept its terms. I agree that this Consent supersedes all previous consents, authorizations, releases, and other written legal permissions signed by me regarding Use and Disclosures of the PHI covered by this Consent, and I release BPMC and its health care providers from all liabilities related to their compliance with this consent.

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**Print Patient’s Name Patient’s Signature, Natural or Legal Guardian**

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**Date**