# Consent to Release Personal Health Information and Acknowledgment of Receipt of Notice of Privacy Practices

I individually or on behalf of the patient authorize CLW to use and disclose my health information as required for treatment, payment and healthcare operations as described in CLW's Notice of Privacy Practices. I hereby acknowledge that I have been given a copy of CLW's Notice of Privacy Practices on the date written below.

Signature:_____

Print Name:_____ Date:_____

If signed by personal representative, list relationship to the patient:_____

**I request that other specific parties have, (or not have) access to my records, please list these persons below:**

| Person's Name (Print) | Relationship | Can Access | Cannot Access |
|---|---|---|---|
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**Official Use Only:**

If CLW is unable to obtain an acknowledgment of receipt of the notice of privacy practices, explain why:

CLW's employee signature:_____

Print Name:_____ Date:_____