ACKNOWLEDGMENT
Receipt of Notice of Privacy Practices

Please sign and return to PANTHERx Specialty by faxing this form to: 855-246-3986
Or mailing this form to:

PANTHERx Specialty Pharmacy
24 Summit Park Drive
Pittsburgh, PA 15275

ACKNOWLEDGMENT OF RECEIPT OF THIS FORM MUST BE SIGNED BY THE PATIENT OR RESPONSIBLE PARTY AND RETURNED TO PANTHERx SPECIALTY, LLC.

The Health Insurance Portability and Accountability Act (HIPAA)
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ______________________________ Date of Birth: ______________

I acknowledge receipt of PANTHERx® Specialty Pharmacy's Notice of Privacy Practices.

I consent to uses and disclosures described in the "HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU" section of the PANTHERx Specialty Pharmacy Notice of Privacy Practices.

Signature: ______________________________ Date: ______________

If signed by personal representative (guardian/parent/other legal representative):

Name of Representative: ______________________________

Describe Relationship to Patient: ______________________________

THIS SECTION TO BE COMPLETED BY PANTHERX SPECIALTY PHARMACY

Reason signature not obtained:

- ☐ Patient too sick to sign at this time
- ☐ Patient refused to sign
- ☐ Other: ______________________________