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PRIVACY PRACTICES ACKNOWLEDGEMENT

Name: ____________________ **Date of Birth:** __________

I have received the Notice of Privacy Practices. I wish to be contacted in the following manner (*check all that apply*):

□ Home/Cell Phone: ________________

- □ O.K. to leave appointment information on voice mail
- □ O.K. to leave detailed information on voice mail
- □ Leave message with call-back number only.

□ Work Phone: _______________

- □ O.K. to leave detailed information on voice mail
- □ Leave message with call-back number only.

My medical records may be discussed with the following family/friend(s). *(Please list anyone you would like us to be able to leave a message with or discuss your medical information with):*

□ Spouse/Significant Other – Name: _____________________

□ Others: ____

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Signature: ____________________ **Date:** __________

Date Reviewed/Changes Made (Please initial and Date):

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