Acknowledgement of Review of Notice of Privacy Practices

We are required to provide you with our "Notice of Privacy Practices". Please review this information. Return the completed coversheet to the receptionist. You may keep the attached Notice or return it along with the coversheet.

Please provide the information below.

Your Name (Patient)(please print)_____

Date of Birth _____

I have been provided with a copy of the "Notice of Privacy Practices".

Your Signature (Patient or Personal Representative) _____

*If a personal representative – description of personal representative's authority::*_____

_____
Date

Please list below the names, relationship, and phone number of any authorized individuals (spouse, family members, friends, caregivers, etc.) that we may discuss your medical or financial information with.

	NAME	RELATIONSHIP	PHONE NUMBER
1.			
2.			
3.			

May we leave medical information on your "home" answering machine? Yes ____ No _____

May we leave appointment information on your "home" answering machine? Yes ____ No _____

_____
Signature of Patient/Parent/Legal Guardian Date

OR

If you do not want any of your medical or financial information discussed with anyone other than yourself please sign below.

_____
Signature of Patient/Parent/Legal Guardian Date

The above information is private and confidential and will be placed in your medical chart. The information on this form will remain valid until we are notified otherwise.