Acknowledgment of Receipt of Notice of Privacy Practices

(to be filed in patient's medical records)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outling my rights regarding my health information

SIGNED: _____ DATE: _____

Relationship (if not signed by patient): _____

I authorize my medical information to be released to (**friends/family members**):

_____

_____

Contact Record

Please contact me as follows: (check at least one):

____ Home/Cell Telephone ( )_____

- ____Leave message with appt. date & time
- ____ Leave message with call-back number only
- ____ Leave message with test results
- ____ Do not leave message

____ Written Communication

- ____ Mail to my home address
- ____ Mail to my work address
- ____ E-mail me my test results: _____

____ Work Telephone ( )_____

- ___ Leave message with appt. date & time
- ___ Leave message with call back number only
- ___ Leave message with test results
- ___ Do not leave message

Home Address: _____

_____

Work Address: _____

_____

Print Patient Name Birth date Date