ACKNOWLEDGMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read, if I so chose) and understand the Notice.

_____ _____

Patient Name (please print) Date

My preference for being contacted(check all that apply):

- Email _____
- Phone_____

Home Cell Work (circle one)

I permit office staff to (check all that apply):

- Leave a voicemail on the home phone or cell phone _____
- Leave a message with the person who answers the phone _____
- Contact me at work and tell who is calling if asked _____
- Leave a message on the work phone voice mail _____
- Contact me via email or other non-secured electronic methods _____

I authorize communication about my medical information with the following:

- Spouse/Parent:_____
- Other (Specify & list Contact information)

_____

_____

_____

Patient Signature

_____

Parent or Authorized Representative (if applicable)