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Notice of Privacy Practices Acknowledgement Form

THE NOTICE OF PRIVACY PRACTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AS IT EXPLAINS:

- How this office will use and disclose your protected health information
- Your privacy right with regard to your protected health information
- This office's obligations concerning the use and disclosure of your protected health information

Release of Medical Information:
My preferable method of contact is:

☐ Phone: _____ ☐ Home ☐ Cell ☐ Work

May we leave a detailed message? ☐ Yes ☐ No

☐ Follow My Health Patient Portal

☐ Postal Mail: _____

You may discuss my medical information with:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

I acknowledge that I have received a copy of the office Notice of Privacy Practices. I further acknowledge that the office Notice of Privacy Practices is available at the front desk upon request.

_____ _____
Patient or Patient Representative Signature Date

_____
Patient or Patient Representative Printed Name