

**NOTICE OF PRIVACY PRACTICES**

**Acknowledgement Form**

**I only acknowledge that I have received the Notice of Privacy Practices**

_____	_____
Name of Patient	Date of birth
_____	_____
Patient's Signature	Date
_____	_____
Witness's Signature	Date

\_\_\_\_\_  
Reason Given by Patient if Refusing to Sign this Notice

\_\_\_\_\_  
Recorder's Signature

**Instructions for Communication**

I authorize my doctor or staff to **leave messages** including certain medical information:

- YES    On my answering machine or voice mail     at HOME  
 at WORK  
 of my MOBILE / CELL Phone

**OR** with the following individuals:

- My spouse or significant other \_\_\_\_\_  
 My son or daughter \_\_\_\_\_  
 Any relative \_\_\_\_\_  
 Other \_\_\_\_\_

This information may include information such as:

- Lab test and x-ray results                       Instructions regarding treatments or medications  
 Information regarding prescription refills  
 Information regarding appointments

- NO    I prefer that my doctor or staff speak to me personally regarding any medical information. Please **do not leave messages** concerning medical information.

I understand that I may notify the doctor's office at any time of changes to this request, which would require a new form to be completed.

_____	_____
Signature	Date

