



St. Francis Medical Group

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 on my:

- 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 is to 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