NOTICE AND ACKNOWLEDGMENT

I acknowledge that I have received the attached Notice of Privacy Practices.

PATIENT OR PERSONAL REPRESENTATIVE'S NAME	
PATIENT OR PERSONAL REPRESENTATIVE'S SIGNATURE	DATE

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

We may use your information to contact you. For example, we may mail you an appointment reminder card or call you with information regarding your care. If you are not at home, this information may be left on your answering machine or with the person who answered your phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care. Please designate who our office CAN disclose your health information to by checking the boxes below:

☐ **OK to spouse:**.....

☐ **OK to ALL family members. Please list names of family members:**

.....

.....

☐ **OK to other:**.....

☐ **OK to leave health information on answering machine or voicemail.**

☐ **DO NOT RELEASE INFORMATION to anyone other than myself, the patient.**

☐ **DO NOT RELEASE to:**.....

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