

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of this practice's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and I request the following restrictions concerning the use and disclosure of my personal medical information: _____

Furthermore, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulation pertaining to medical assignment of benefits applies.

Patient / Guardian: _____ Date: _____

Witness: _____ Relationship: _____

Patient refused to sign this acknowledgement. Date: _____

PATIENT PERMISSIONS TO THE PRACTICE SHEET

- YES NO We may leave test instructions, medication refill information, test / lab work results, or appointment information on your voicemail or answering machine.
- YES NO We may give test instructions, medication refill information, test / lab work results, or appointment information to an immediate family member.
- YES NO We may discuss your medical condition and / or diagnosis with an immediate family member.
- YES NO We may fax / send your medical records to your primary care physician, Dr. _____.
- YES NO We may fax / send your medical records and insurance information to a hospital, doctor's office and / or relative.

Patient Name: _____ Fax #: _____

Signature: _____ Date: _____