Acknowledgement of Receipt of Notice of Privacy Practices and Communications Consent

I acknowledge that I have received or have been offered a copy of the Notice of Privacy Practices.

_____

Patient or Personal Representative Signature Date

_____

Print Name

If a personal representative's signature appears above, please describe personal representative's relationship to the patient below.

_____

_____

_____

I give permission to be contacted in the following manner (check all that apply):

☐ Work Telephone	☐ Written Communication
☐ Ok to leave message with information	☐ OK to mail my home address
☐ Leave message w/ call back #	☐ OK to mail work/office address
☐ Home Telephone	☐ OK to fax to this number:
☐ OK to leave message w/ information	☐ Cell phone number
☐ Leave message w/ call back # only	
☐ OK to send e-mail address:	
☐ OK to leave message at home with the following family members:	
☐ Patient Information or medical records may be faxed to other Care Providers, hospitals, or insurance companies if necessary.	
Patient Signature:	Date: