Notice of Privacy Practices

I understand the clinical and administrative staff may review my medical records and lab reports, but my records will be kept confidential and will not be released without my written consent.

Acknowledgement of Review of Notice of Privacy Practices

I,_____ have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Printed Name_____

_____ Date_____
Patient /Guardian Signature

Disclosure of Patient Information

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

_____

_____

_____

Please list the family members or other persons, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY

Name_____ Phone #_____

Name_____ Phone #_____

Please print the telephone number where you want to receive calls about your appointments or other health care information if other than your home.

Phone #_____

I am fully aware that a cell phone is not a secure and private line.

Printed Name_____

_____ Date_____
Patient /Guardian Signature