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 I am entitled to receive a copy of this document.

Furthermore, I authorize my physician and his/her staff, to contact me by the designated means below: (Check all that apply)

Home Phone
Home Answering Machine/Voice
Mail Office/Work Place, Voice Mail
Cell Phone/Voice Mail

Additionally, by my **initials,** I authorize my physician and his/her staff, to communicate information regarding appointments, medical results, and billing issues to:

Initials	Name	Phone	Relationship

This Authorization shall remain in force until revoked in writing, Attention of Privacy Officer

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Signature of Patient or Personal Representative

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Date

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Name of Patient or Personal Representative

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Description of Personal Representative