

## 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 disclosed. I understand that I am entitled to receive a copy of this document at no cost to me.

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
Date

### **Appointment Reminders, Treatment alternative, and other Health-Related Benefits:**

To provide appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of concern or interest to you.

Please circle each method listed below that we may use to contact you:

- Mail
- Home telephone
- Cell telephone
- Work telephone
- E-mail
- Leaving a message on answering machine

Disclosures to Family, Loved-Ones and Friends Who Have Supporting Role In Your health care and/or treatment. This practice will comply with your request to share personal health information with person/s listed below for test results, picking up prescription, equipment, directions or other items associated with your care. Please list person/s and relationship.

\_\_\_\_\_  
Name Relationship Contact number

\_\_\_\_\_  
Name Relationship Contact number

\_\_\_\_\_  
Name Relationship Contact number

NOTE: Revocation or limitations to this document must be in writing and sent to the HIPAA Compliance Office.