

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

### **\*You May Refuse to Sign This Acknowledgement\***

I have read the Notice of Privacy Practices from the above-named practice. In addition, I want the following information to become part of my permanent record. I understand that I can make changes to this document at any time. I also understand that I can request a copy of this document at any time.

I want to authorize leaving messages on my answering system.

**HOME:** \_\_\_YES \_\_\_NO    **WORK:** \_\_\_YES \_\_\_NO    **CELL:** \_\_\_YES \_\_\_NO

The staff of The Medical Care Group, LTD. may leave appointment reminder messages with the following people who may answer my **home, work, or cell** phone:

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

I authorize DRs, NPs, PAs or other delegated staff to discuss my protected health care information with the following people:

Spouse/Significant Other (NAME): \_\_\_\_\_

Other Family Member(s) (NAME): \_\_\_\_\_

Other Persons or Entities (e.g. research coordinator): \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_

**PARENT/GUARDIAN(IF UNDER AGE 18):** \_\_\_\_\_

**RELATIONSHIP TO PATIENT:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_      **DATE:** \_\_\_\_\_