My signature below is acknowledgement of receipt of the Notice of Privacy Practices

____________________	____________________	__________
Printed Patient Name	Patient Signature	Date
Signature of Patient Representative (required if patient is a minor or unable to sign)	Relationship to Patient	Date

Persons Authorized to Receive Information

Name of Person	Relationship	Date of Birth
Name of Person	Relationship	Date of Birth
Name of Person	Relationship	Date of Birth

_______________ (please initial) I authorize the person(s) listed above to receive all health information about appointments, treatment, insurance, and/or other information contained in my records.

_______________ (please initial) I do not authorize the following information to be released to anyone other than myself: (please specify) ____________________________________

Telephone Preferences

Please give us permission or denial for calling you in reference to appointments, schedule changes, etc. We do not give out medical information except to you and your authorized representatives, and we do not leave sensitive information on a message.

Please circle your responses

May we call you at your home number? YES NO N/A May we leave a message? YES NO N/A

May we call you at your work number? YES NO N/A May we leave a message? YES NO N/A

May we call you on your mobile number? YES NO N/A May we leave a message? YES NO N/A

____________________________________ ____________________
Signature of Patient or Patient Representative Date