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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the above named practice's Notice of Privacy Practices.

Client's Name (print)

Date

Client's Signature

Date

Parent or Guardian Name (print)

Date

Parent or Guardian Signature

Date

_____ (Initial) I authorize you to leave messages on my home answering machine or cell phone in regard to appointments and answers to my medical questions when in the judgment of the office this would be in my best interest.

_____ (Initial) I authorize you to leave messages with other family members or friends that answer my home phone when in the judgment of the office this would be in my best interest.

_____ (Initial) I authorize you to leave messages at my place of employment for me to return your calls.

_____ (Initial) I authorize you to E-mail messages in regard to appointments and answers to my medical questions to this E-mail address _____.