ACKNOWLEDGMENT 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 that I am entitled to receive a copy of the document.

Futhermore, by my specific **initials**, I authorize my physician and his/her staff to contact me by the designated means noted below.

_____ Home Phone

_____ Home Answering Machine/Voicemail

_____ Office/Work Place, Voicemail

_____ Cell Phone/Voicemail

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

_____ Spouse _____

_____ Others _____

_____

_____

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

_____ Signature of Patient or Personal Representative

_____ Date

_____ Name of Patient or Personal Representative

_____ Description of Personal Representative's Authority