ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below, I authorize being contacted for practice reminders by:
Email_______; at email address ____;
Text _____Telephone number____;
By voice mail ____________;

By checking the lines below, I authorize being contacted for birthday greetings or promotions about the practice by:
Mail _______; Text_____; Email_____

By checking the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. _______

________________________________ ________________________
Patient Name (**please print**) Date

____
Signature of Patient, Guardian, or Patient's legal representative

List below the names and relationship of people to whom you authorize the Practice to release PHI (Private Health Information).

_____________________________ _______________________________

_____________________________ _______________________________

_____________________________ _______________________________

_____________________________ _______________________________

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.