

# PRIVACY NOTICE

## Acknowledgment of Receipt of Privacy Notice *Original to be maintained in Patient's permanent medical record.*

I acknowledge, by my signature below, that I have received a copy of the office's  
*Notice of Privacy Practices.*

### RELEASE OF INFORMATION

**NOTICE : THIS RELEASE OF INFORMATION FORM SUPERSEDES ANY OTHER  
RELEASE OF INFORMATION FORM ON FILE IN THIS OFFICE, AND IS EFFECTIVE UNTIL  
REVOKED BY ME IN WRITING.**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

May we leave a message on your answering machine regarding your test or exam  
results, appointments, billing information or medication refill? YES \_\_\_\_\_ NO \_\_\_\_\_

May we mail or fax you copies of any lab, xrays, or other test results with a verbal  
request from you? YES \_\_\_\_\_ NO \_\_\_\_\_

Who else can our office talk with regarding your medical and treatment information?

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

Relation to Patient: \_\_\_\_\_ and

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

Relation to Patient: \_\_\_\_\_

(If more names are authorized, use the bottom of this form to state name and relationship.)

\_\_\_\_\_  
Patient or legally authorized individual **SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
Printed Name, if signed on behalf of the patient

\_\_\_\_\_  
Relationship (parent, legal guardian,  
representative, etc.)