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:

Mail _____;

Email _____; at email address:

_____;

Telephone numbers _____; at numbers:

_____;

By Voice Mail _____;

By Text Message _____;

By Facebook address _____.

By checking the lines below I authorize being contacted for birthday greetings or promotions about the practice by:

Mail _____;

Email _____; at email address:

_____;

Telephone Numbers _____;

_____;

By Voice Mail _____;

By Text Message _____;

By FaceBook Address _____.

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

_____ _____

Patient Name (PRINTED) Date

Signature of Patient, Parent, Guardian or Patient's Legal Representative

Name of Parent, Guardian or Patient's Legal Representative (PRINTED)

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

List below the names and relationship of people to whom you authorize the Practice to release PHI

_____ _____

_____ _____

_____ _____