

NOTICE OF PRIVACY PRACTICES- ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting The Office Manager.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

May we leave a message on your home recorder? YES ___ NO ___

May we leave a message with people at your house? YES ___ NO ___

May we discuss your test results with members at your house? YES ___ NO ___

Please list family members with whom we may discuss test results.

Name _____

Name _____

By my signature below I acknowledge acceptance of the Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian,
personal representative)