



PRIVACY POLICY

I hereby acknowledge that I reviewed a copy of this medical practice's Notice of Privacy Practices. Please indicate by signature below that you are authorizing us to use private patient information as indicated in our notice of Privacy Practices.

SIGNED: _____

PRINT NAME: _____

RELATIONSHIP: _____
(IF OTHER THAN THE PATIENT)

As a policy we will not share information outside of allowances in the Privacy Policy. If you would like to specifically permit sharing with family, spouses, partners or others please include names and relationships below:

EMAIL AND VOICEMAIL

PLEASE REVIEW AND INITIAL BELOW:

I understand that it is sometimes helpful to leave voice messages on cellular and home phones. By initialing above I am agreeing to allow Marina Village Medicine to leave administrative as well as clinical voice messages at the phone numbers I have provided to them.

I understand that Marina Village Medicine uses standard (non-secure) email for all communication. By initialing above I am indicating that wish to communicate with the office using standard email.

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