Acknowledgement of Review of Notice of Privacy Practices

_____**Initial** – I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

Please select all that apply below.

__ I give permission to leave a message on my **voicemail** concerning my personal health information.

__ I **do not** give permission to leave a message on my voicemail concerning my personal health information.

__ I hereby give permission to communicate via email, which may include appointment reminders, patient survey, patient newsletter, and/or medical alerts such as medication recalls. My email address in on the front of this form. We do not release personal information to third party venders; it is for CorCare use only.

General Consent for Care and Treatment Consent

_____**Initial** –this consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. You have the right to discuss the treatment plan with our physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Name of CorCareTX Witness Signature of CorCareTX Witness