Marcella Bonnici, MD

ACKNOWLEDGEMENT OF PRIVACY PRACTICES AND INSTRUCTIONS FOR RELEASE OF PERSONAL HEALTH INFORMATION

PATIENT NAME:_____ DATE OF BIRTH_____
PHONE #_____SOCIAL SECURITY #:_____
Email Address: _____
I acknowledge that I have received a copy of the Dr. Marcella Bonnici's Notice of Privacy Practices.

I give permission to Marcella Bonnici, M.D. to release and discuss my personal health information to/with:
Name: _____Relationship: _____
Name: _____Relationship: _____
Name: _____Relationship: _____

I give permission to Marcella Bonnici, M.D. to communicate messages regarding appointments as follows:
___You may leave a message on my answering machine / Cell Phone
___You may text message my appointment to: _____
___You may leave a message with:
Name: _____Relationship: _____
Name: _____Relationship: _____
Name: _____Relationship: _____

I give permission to Marcella Bonnici, M.D. to communicate messages regarding referrals to another physician as follows:
___You may leave a message on my answering machine / Cell Phone
___You may send a letter via U.S. mail
___You may send an email to: _____

I give permission to Marcella Bonnici, M.D. to communicate messages regarding lab results, x-rays, and other tests as follows:
___You may leave a message on my answering machine / Cell Phone
___You may send a letter via U.S. mail
___You may send an email to: _____

Other Instructions for the release of personal health information: _____
_____

My Preferred method of communication is (please circle): U.S. Mail Email Phone

Patient/Legal Guardian's Name: _____
Patient Signature or Legal Guardian: _____ Date: _____