A-Z Internal Medicine
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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

May we leave a detailed message on your answering machine regarding your medical results? Yes _____ No _____

Who may we speak to regarding your results, condition or medication? If left blank it will be considered N/A

Name _____ Relationship _____

_____

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