Acknowledgment of Receipt of Notice of Privacy Practices

I, _____(patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information. I understand that this facility reserves the right to change their Notice of Privacy Practices and that I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement.

___I would like to authorize the release of my medical/dental information to the following individuals:

_____

I authorize the doctor and staff to communicate with me via:

___Text Message

___Email

___Voicemail

I understand that these communications may contain medical/dental information.

Date: _____

Signature of Individual or Legal Representative: _____

Printed Name of Individual or Legal Representative: _____