ACKNOWLEDGEMENT OF RECEIPT OF: PRIVACY PRACTICES OFFICE POLICY AND PROCEDURES

I, ______________________________ have received the Notice of Privacy Practices and the Office Policy and Procedures from Primary Health Associates.

Signature: ____ Date: _______________

Circle One

1. **My medical care may be discussed with my spouse/children significant other** **yes/no**
2. **Test results may be left on my answering machine/voice mail** **yes/no**
3. **Appointment information may be left on my answering machine** **yes/no**

If Applicable: For personal representative of the patient

Print Name of Personal Representative: ____

Describe Personal Representative Relationship: ________________________________
(Parent, guardian, etc):

Signature of Personal Representative: ____

Date: ______________________

For Practice use only:
Signature of Practice Employee: ________________________ Date: _____________