



**ACKNOWLEDGEMENT OF RECEIPT OF:
PRIVACY PRACTICES
OFFICE POLICY AND PROCEDURE**

I, _____ have received the Notice of Privacy
(Print Name)
**Practices and the Office Policy and Procedures from Primary Health
Associates, P.C.**

Signature: _____ **Date:** _____

- | | |
|---|-----------------------|
| 1. My medical care may be discussed with my spouse,
parent, child or significant other named: _____
_____ | Circle One
Yes/ No |
| 2. Test results may be left on my voicemail or machine | Yes/No |
| 3. Appointment information may be left on voicemail or
machine. | Yes/No |

If Applicable: For Personal Representative of the Patient:

Print Name of Personal Representative: _____

Describe Personal Representative: _____
(Parent, guardian, etc.)

Signature of Personal Representative _____ Date: _____

For Practice use only:

Signature of Practice Employee: _____ *Date:* _____