ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for practice reminders by:
Mail _____;
Email_____; at email address _____;
Telephone numbers_____;
_____;
By voice mail _____;
By text message _____;
By FaceBook address _____.

By checking this checking the lines below I authorize being contacted for birthday greetings or promotions about the practice by:
Mail _____;
Email _____ at email address _____;
Telephone numbers_____;
_____;
By voice mail _____;
By text message _____;
By FaceBook address _____.

By checking this checking the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. _____

_____ _____
Patient Name (please print) Date

_____
Name of Parent, Guardian or Patient's legal representative

Signature of Patient, Parent, Guardian or Patient's legal representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____	_____
_____	_____
_____	_____