



NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

Where would you prefer we contact you with **CONFIDENTIAL** information regarding your treatment or test results? **Please leave at least one number where we could leave you a message.**

Home: Yes _____ Number: _____ Voicemail okay?
Yes _____ No _____
No _____

OR Work: Yes _____ Number: _____ Voicemail okay?
Yes _____ No _____
No _____

OR Cell: Yes _____ Number: _____ Voicemail okay?
Yes _____ No _____
No _____

I give permission for medical information about me to be shared with the following:

_____ (Signature of Patient)

By my signature below, I acknowledge receipt of the Notice of Privacy Practices and give my permission regarding a confidential voice message as stated above.

I also hereby authorize my insurance benefits to be paid directly to Grove Street Family Clinic, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers for payment of claims. I also authorize the release of information I request to be sent to insurance companies or employers (including disability forms).

PRINT NAME

Date of Birth

Patient or legally authorized individual signature

Today's Date

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian)

This form will be retained in your medical record.