Grove Street Family Clinic

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.**

				Voicemail okay?
	Home: Yes_____	Number: _____		Yes_____ No_____
	No _____			
				Voicemail okay?
OR	Work: Yes_____	Number: _____		Yes_____ No_____
	No _____			
				Voicemail okay?
OR	Cell: Yes_____	Number: _____		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.