Acknowledgement of Receipt of Notice

My signature below indicates that I have been provided with a copy of the Family Medical Associates' ***Notice of Privacy Practices***, and have had an opportunity to ask questions concerning this policy.

_____ _____

Signature of Patient or Legal Representative *Date*

_____

Representative's Relationship to Patient

Preferences for Patient Notification

My signature below indicates the method(s) in which I choose to be contacted in the event that I need to be notified of information concerning my healthcare. My consent is also given to contact the individuals listed below in case I cannot be reached. My preferences checked below will remain in effect until changed by me in writing. Please contact me: ***(Check all that apply)***

By Mail: **Alternate Address or Telephone:**

☐ Home Address ☐ Other: _____

_____

By Telephone: _____

☐ Home Telephone ☐ Other: _____

☐ Work Telephone _____

☐ Answering machine/Voice mail
_____Home only
_____Work only
_____Both

Permission to Inform Others

I give my consent to Family Medical Associates to inform the following individuals of important information concerning my healthcare in the event I cannot be reached: ***Provide name of individual(s).***

Name: **Relationship to Patient:**

_____ _____

_____ _____

_____ _____

_____ _____

Signature of Patient or Legal Representative *Date*

_____

Representative's Relationship to Patient