This form will need to be updated yearly

Notice of Privacy Practices

Patient Name:____ Date of Birth:_______________

Preferred Phone Number:____

I authorize my doctor or staff to leave messages including information such as: Pathology/Lab results, Instructions regarding treatments, medications, prescription refill information, appointments and billing/insurance information.

____ Yes: On my answering machine or voice mail:

____ At Home ____At Work ____ on my mobile/cell phone

Or with the following individuals (list names of people we can talk with and their phone numbers)

____ My Spouse or significant other____

____ My Son/Daughter____

____ Any Relative____

____ Other____

Primary Doctor: ____

____

Signature Date