

# PREMIER HEALTH S.C.

## ACKNOWLEDGMENT OF RECEIPT OF PRIVACY POLICY

Patient Name \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_

**By signing this form you acknowledge that you have received a copy of Internal Medicine Clinic's Notice of Privacy Policy Practices explaining:**

- **Our privacy practices for using and disclosing your health information.**
- **Your privacy rights with regard to your health information.**

### INFORMATION REQUESTED FOR PATIENT RELEASE

(circle Yes or No)

**MAY WE CONTACT YOU AT WORK? YES NO NUMBER ( ) - \_\_\_\_\_**

**MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE REGARDING APPOINTMENTS AND LAB RESULTS? YES NO**

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### FRIENDS/ FAMILY MEMBERS YOU GRANT US PERMISSION TO DISCLOSE PERSONAL HEALTH INFORMATION TO:

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

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***I the undersigned have received a NOTICE OF PRIVACY POLICY from Internal Medicine Clinic and hereby agree to undergo/ continue treatment in this facility. I understand that I may revoke this consent in writing.***

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date