ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This office of **Colin D. Pero, MD,** is required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

_____ _____

Patient Name (Please print) ***Date of birth***

Which of the following methods do we have permission to contact or leave messages for you regarding your appointments, medication, promotional events or financial information?

_____ Home _____-_____-_____ ____ Cell _____-_____-_____

_____ Work _____-_____-_____ ____ Email: _____

_____ Home address: _____

Other than your insurance carrier and primary physician, whom may we talk to about your healthcare information?

_____ Spouse Name _____ Phone #_____-_____-_____

_____ Child Name _____ Phone #_____-_____-_____

_____ Child Name _____ Phone #_____-_____-_____

_____ Parent Name _____ Phone #_____-_____-_____

_____ Other Name _____ Phone #_____-_____-_____

I acknowledge that I have received a copy of this office's Notice of Privacy Practices and I have had an opportunity to review it.

_____

Signature of Patient or Guardian ***Date***

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgement.

☐ We weren't able to communicate with the patient.

☐ Other *(Please provide specific details)*

_____

Employee signature Date