PERSONALIZED PHYSICIANS

Acknowledgment of Receipt of "NOTICE OF PRIVACY PRACTICES"

For Protected Health Information

Patient Confidentiality

Patient Name: _____

Patient Date of Birth: _____

Patient confidentiality is a top priority at Personalized Physicians. Therefore, it is important that you provide us with the following information to ensure that there is no violation of your privacy.

It is our experience that some patients may or may not wish for our staff to discuss medical conditions/information with family members. Please indicate any family members or other individuals who may obtain or call and discuss your medical information. **Please also include their telephone number.**

☐ Spouse/Partner _____

☐ Child _____

☐ Child _____

☐ Parent _____

☐ Other Individual(s) _____

I acknowledge that I have received a copy of Personalized Physicians' "Notice of Privacy Practices" for Protected Health Information on the date set forth below.

_____ _____

Signature of Patient Date of Receipt

_____ _____

Printed Name of Authorized Personal Representative Relationship to Patient

_____

Signature of Authorized Personal Representative