PROGRESSIVE PODIATRY

NOTICE OF PRIVACY PRACTICES

Patient Name:_____
Date:_____

ACKNOWLEDGEMENT & COMMINICATION PREFRENCES

Combined Notice of Privacy Practices Receipt and Alternate Communication Request

Your privacy is important to us. This form confirms that you have received our Notice of Privacy Practices and lets us know how we may communicate with you about your care.

1. ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (Please Print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

2. ALTERNATE COMMUNICATION REQUEST

I wish to be contacted in the following manner by numbers listed in chart (check all that apply):

Home	Alternate	
☐	☐	O.K. to leave a message on voicemal
☐	☐	O.K. to leave message with individual
☐	☐	Leave message with call back number only
☐	☐	Do not leave a message

3. PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____

Relationship of Representative to Patient (if applicable):_____

Signature of patient or responsible person:_____ Date:_____

4. ADDITIONAL AUTHORIZATIONS

I give permission to the following individuals to obtain the indicated information:

_____ whose relation to me is _____ Phone:_____
Name Relationship

_____ whose relation to me is _____ Phone:_____
Name Relationship

_____ whose relation to me is _____ Phone:_____
Name Relationship

- ☐ Prescription refills on my behalf
- ☐ Set up/Cancel appointments
- ☐ Test results on my behalf
- ☐ Speak by telephone on my behalf
- ☐ Pick up prescriptions, orders, or other needs with a photo ID

_____ _____
Effective Date Expires

_____
Revoked

By signing this waiver I release Progressive Podiatry and its staff therein, from any liability for release of information pertaining to my medical care.