Patient Name _____
(please print)

PROVIDENCE MEDICAL GROUP

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicates that you have been given the opportunity to review and/or request a copy of the Providence Medical Group Notice of Privacy Practice on the date indicated. If you have any questions regarding the information in the Providence Medical Group's Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the Medical Group's Patient Privacy Officer as indicated on your Notice.

Patient Signature _____ Date _____

[+]The above authorization is required by Federal Law under HIPAA regulations.

Medical Information Authorization

☐ ***I DO NOT** authorize Providence Medical Group to leave a **voicemail message** on my phone which I provided to you in my demographic information.

☐ ***I DO** authorize Providence Medical Group to leave a **voicemail message** on my phone which I provided to you in my demographic information.

☐ ***I DO NOT** authorize the physician or anyone associated with Providence Medical Group to discuss my **medical condition, treatment or test results** with anyone other than myself.

☐ ***I DO** authorize the physician or anyone associated with Providence Medical Group to discuss my **medical condition**, **treatment and test results** with the following people (family/friends, not to include physicians):

_____

Name Phone Relationship

_____

Name Phone Relationship

_____

Name Phone Relationship

Signature of patient or legal representative Date

_____

Printed name of patient/legal representative Relationship