

Privacy Practices Acknowledgement and Consent Form

- ◆ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.
- ◆ I agree that telephone messages regarding my appointments, prescription renewals, test/lab results, and all other Protected Health Information* ("PHI"), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Home / Office / Cell / Other: _____
1. Okay to leave a call back number only, do not leave message. ___Yes ___No
2. Okay to leave message with a person (Home, Office, Other). ___ Yes ___No
3. Okay to leave a message on your answering machine at your home. ___Yes ___ No

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Home / Office / Cell / Other: _____
1. Okay to leave a call back number only, do not leave message. ___Yes ___No
2. Okay to leave message with a person (Home, Office, Other). ___ Yes ___No
3. Okay to leave a message on your answering machine at your home. ___Yes ___ No

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Home / Office / Cell / Other: _____
1. Okay to leave a call back number only, do not leave message. ___Yes ___No
2. Okay to leave message with a person (Home, Office, Other). ___ Yes ___No
3. Okay to leave a message on your answering machine at your home. ___Yes ___ No

[If we need to contact you with test results, please place a check mark next to the preferred contact number, if any.]

◆ I agree that my PHI may be shared with my spouse. ___ Yes ___ No

◆ I agree that my PHI may be shared with the following other people:

_____	_____
_____	_____
_____	_____

◆ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Neurology Medical Group of Diablo Valley, Inc

**as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name (print): _____

Signature: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____