Privacy Notice Acknowledgment & Communications

This acknowledgment is not the practice Notice of Privacy Practices. The complete notice must be supplied separately.

NOTICE OF PRIVACY PRACTICES

☐ I acknowledge that I received or was offered the practice Notice of Privacy Practices.

If not acknowledged, staff explanation / good-faith effort

PEOPLE AUTHORIZED FOR ROUTINE COMMUNICATION

Name

Relationship

Telephone

Information that may be discussed

COMMUNICATION PREFERENCES

☐ Leave appointment-related voicemail

☐ Leave billing-related voicemail

☐ Send appointment text messages

☐ Send non-urgent email

☐ Use discreet wording without procedure names

☐ Do not leave voicemail

☐ Do not send text messages

☐ Do not send email

Electronic communications can be intercepted, misdirected, or viewed by others. Do not use email or text for emergencies or detailed medical information. Preferences may be changed in writing.

RESTRICTIONS REQUESTED

Describe any requested privacy restriction or confidential communication method

SIGNATURE

Printed name

Date

Signature (sign after printing or use an approved e-signature workflow)

By signing, I confirm that I reviewed this form and that the information I provided is accurate to the best of my knowledge.