## Privacy Practices Acknowledgment and Consent Form

☐ I have received your provided an opportunity	Notice of Privacy Practices y to review it.	and/or I have been
renewals, lab results, ar may be left for me on	messages regarding my appoind all other Protected Health Invoicemail systems and answer ambers, in addition to any other.	nformation* ("PHI"), ering machines at the
□ (	- — - □ Home/Office/Cell/E	Email
□ ( <u> </u>		Email
[If we need to contact you with Lab results, p	lease place a check mark next to the preferred c	ontact number, if any.]
☐ I agree that my PHI ma	ay be shared with my spouse.	
☐ I agree that my PHI ma	ay be shared with the following	g other people:
Name	Phone Number	Date of Birth
*as defined in the Health Insurance Portability  Patient Name (print):		utions, ("HIPAA")
Signature:	Data	
If the patient is a minor (under 18 years of age), the responsib		ation below.
Parent/Guardian Name (print):	Relationship to Patie	nt:
may be further disclosed by such recipient for the	oing agreements, at any time, by giving written no purposes referenced above and that my PHI mease of such information. I also understand that is e will not be held liable for damages.	ay no longer be protected by state and
	Patient Portal	
Our highly secured, online Patient Porta 24/7 access to your medical information please refer to the materials posted in the	online as well as several other great	benefits. To find out more,

If you would like to opt out of the patient portal, then please check the following box.  $\Box$