



RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I hereby acknowledge that on _____ I received the Notice of Privacy Practices from Wright State Physicians, which sets forth the ways in which my personal health information may be used or disclosed by Wright State Physicians, and outlines my rights with respect to such information.

Patient's Signature

Date

COMMUNICATION/PRIVACY CONSENT FORM

Patient Name _____ DOB _____

Due to new HIPPA regulations and the number of patients who have voice mail and/or answering machines on their telephones, we need some information about how to better communicate with you.

Occasionally it is necessary that we call patients regarding a surgery or appointment time change, test results and/or billing matters.

Please answer the following questions so we may contact you in the most efficient way possible:

May we leave a message on your answering machine at your home? Yes No

May we leave a message on your cell phone? Yes No

May we leave a message on your spouse's/significant others' cell phone? Yes No

May we call you at work? Yes No

May we leave a message on your voicemail at work? Yes No

If we call you at home and you are unavailable,
may we leave a message with another person? Yes No

Please list the person/persons to whom you authorize us to release information, their relationship to you, and their phone numbers:

Name _____ Relationship _____ Phone (_____) _____

Name _____ Relationship _____ Phone (_____) _____

Name _____ Relationship _____ Phone (_____) _____

Patient's Signature

Date