

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices for Charlotte B. Alexander M.D. and I have been provided an opportunity to review it.

Name of Patient (Print or Type)

Date of Birth

Signature of Patient

Date

NAMES OF ANY OTHER INDIVIDUALS THAT YOU ARE AUTHORIZING TO RECEIVE YOUR P.H.I. (PROTECTED HEALTH INFORMATION): (THIS INCLUDES DISCUSSING BILLING, SCHEDULING, TEST RESULTS)
(CHECK ALL THAT APPLY AND PRINT FULL NAMES)

- HUSBAND** _____
- WIFE** _____
- GUARDIAN** _____
- OTHER** _____

THE BEST PLACE TO CONTACT ME FOR ALL P.H.I.
(PLEASE CHECK ONE)

- HOME**
- WORK**
- CELL**