I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the box I authorize being contacted for practice appointment reminders by:

☐ Telephone number  ☐ Voice mail  ☐ Text message

☐ By checking box I authorize being contacted for birthday greetings or promotions about the practice by:

☐ By checking box I authorize the doctor to personally discuss with me products that may benefit my health or condition.

_______________________________   __________________
Patient Name (please print)     Date

_______________________________
Signature of Patient, Parent, Guardian or Patient’s legal representative

THIS FORM WILL BE PLACED IN THE PATIENT’S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

____________________________   ______________________________
____________________________   ______________________________
____________________________   ______________________________