



**RECEIPT OF NOTICE OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGEMENT FORM**

I, \_\_\_\_\_, have received a copy of Dingmans Medical  
(Patient name)

Notice of Privacy Practices.

The Practice may contact me about appointments and results (labs, x-ray, etc.) with the following checked methods and instructions:

<b>Communication</b>	<b>Number or Address</b>	<b>Leave Message Yes or No</b>	<b>Special Instructions</b>
Home Phone			
Work Phone			
Cell Phone			
Email			
Mail			

**Request for Disclosure of Protected Health Information**

I understand that my protected health information will not be disclosed to anyone without my specific authorization and hereby authorize Dingmans Medical staff and/or physician to disclose my protected health information to:

Spouse		Parent	
Children		Friend	

Other: \_\_\_\_\_

Patient/Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_