



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

I, _____, have received a copy of Dingmans Medicals
(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:

Communication	Number or Address	Leave Message Yes or No	Special Instructions
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	
Partner		Other	

Patient/Representative Signature: _____ Date: _____