PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY A CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

Date:_____

I acknowledge receipt of a copy of the current Notice of Privacy Practices for Princeton OB/GYN. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_____ _____

Please *print* your name Please *sign* your name

_____ _____

Legal Representation Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I AUTHORIZE THIS OFFICE TO LEAVE MESSAGES REGARDING **APPOINTMENTS/BILLING INFORMATION** VIA:

- ☐ Cell Phone_____
- ☐ Home Phone_____
- ☐ Work Phone_____

I AUTHORIZE THIS OFFICE TO LEAVE MESSAGES REGARDING **MY HEALTH/TREATMENT INFORMATION** VIA:

- ☐ Cell Phone_____
- ☐ Home Phone_____
- ☐ Work Phone_____