



RECEIPT: PRIVACY PRACTICES, OFFICE POLICY AND PROCEDURES

I, _____ have received the Notice of Privacy Practices and the
(Print Name)
Office Policy and Procedures from Primary Health Associates, P.C.

Signature: _____ Date: _____

- Circle One
1. **My medical care may be discussed with my spouse, parent, child or significant other named:** _____ Yes / No
 2. **Test results may be left on my voicemail or machine.** Yes / No
 3. **Appointment information may be left on voicemail or machine.** Yes / No
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If Applicable: For Personal Representative of the Patient:

Print Name of Personal Representative: _____

Describe Personal Representative: _____
(Parent, guardian, etc.)

Signature of Personal Representative: _____ Date: _____

For Practice use only:

Signature of Practice Employee: _____ Date: _____