PRIMARY HEALTH
ASSOCIATES, P.C.

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:_____