

Patient Release Form & Acknowledgement of Receipt of Notice of Privacy Practices

I. I understand that it is very important for Dr. Sobel.s office to be able to contact me regarding Lab/Xray results or other information. I hereby give permission to Dr. Sobel or a member of his staff to leave information for me in the following ways:

(Please check all that apply)

- _____ 1. Leave test results and other information on my home answering machine.
- _____ 2. Leave test results and other information on my work voice mail.
- _____ 3. Leave test results and other information on my cell phone voice mail.
- _____ 4. Leave test results and other information with

_____ My Spouse (Name)_____

_____ Parent (Names)_____

_____ Adult child (Name)_____

_____ Friend or co-worker (Name)_____

_____ UNTIL (DATE)_____ OR INDEFINITELY (CIRCLE)

- _____ 5. Must contact me personally and directly (no messages). I realize this may cause delays in successfully contacting me.

II. I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signature Date:_____

Relationship (if not signed by patient):_____

I wish to place the following restrictions on disclosure of my health information:

_____ **INTERNAL USE ONLY**

If patient/patient.s representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time) time):_____

By: (Name and title) _____