

**Adult Primary Care Associates of Greater Gwinnett  
Patient Release Form  
&  
Acknowledgement of Receipt of Notice of Private Practices**

**I.** I understand that it is very important for Adult Primary Care Associates of Greater Gwinnett office to be able to contact me regarding Labs/X-rays results or other information pertaining to my health information. I hereby give permission to Adult Primary Care Associates of Greater Gwinnett Staff to leave information for me in the following ways:

**(Please check all that applies)**

\_\_\_\_\_ **1.** Leave test results and other information on my home's answering machine.

\_\_\_\_\_ **2.** Leave test results and other information on my work's voice mail.

\_\_\_\_\_ **3.** Leave test results and other information on my cell phone's voice mail.

\_\_\_\_\_ **4.** Leave test results and other information with:

\_\_\_\_\_ My spouse (Name) \_\_\_\_\_

\_\_\_\_\_ My parents (Name) \_\_\_\_\_

\_\_\_\_\_ An adult child (Name) \_\_\_\_\_

\_\_\_\_\_ Friend or co-worker (Name) \_\_\_\_\_

\_\_\_\_\_ **5.** Must contact me personally and directly (**NO MESSAGES**). I realize this may cause delays in my treatment of my health.

**II.** I have been presented with a copy of the Notice of Privacy Practice, 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.

I am acknowledging that I have received a copy of the Notice of Privacy Practice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship (if not signed by patient): \_\_\_\_\_

**I WISH TO PLACE THE FOLLOWING RESTRICTIONS ON DISCLOSURE OF MY HEALTH INFORMATION:**

\_\_\_\_\_