PRIVACY NOTICE ACKNOWLEDGEMENT

❑ I would like to review the Provider Notice of Privacy Practices at the time of my appointment.

❑ I acknowledge that I will have the opportunity to review the Provider Notice of Privacy Practices, but choose not to.

❑ **I authorize Cornerstone Medical Group to leave medical information on my voice mail and or answering machine.**

❑ **I consent to the release of verbal information regarding my diagnosis/test results/treatment plan to**

❑ **Spouse** ❑ **Children** ❑ **Family Members**

❑ Patient received a copy of the Provider Notice of Privacy Practices for review.

❑ PATIENT REFUSED TO SIGN ACKNOWLEDGEMENT:

_____ _____

Name of Patient (printed) Signature: Patient or Guardian

_____

DATE

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