Acknowledgement of Receipt of Privacy Notice

Family Care Partners

NAME OF PATIENT	DATE OF BIRTH

I hereby acknowledge that I have received a copy of Family Care Partner's Notice of Privacy (NPP). NPP Pub date: 30 December 2015

Signed: ____ Date: ___________________________

Print Name: _______________________________DOB: ______________Phone: ________________

If not signed by the patient, please indicate the relationship:

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient

PATIENT CONFIDENTIALITY:

FAMILY CARE PARTNERS AND ITS EMPLOYEES ARE BOUND BY FLORIDA STATUTE 395.017 WHICH PROVIDES THAT PATIENT MEDICAL RECORDS ARE PRIVILEGED AND CONFIDENTIAL AND MAY NOT BE DISCLOSED WITHOUT THE CONSENT OF THE PATIENT. NO PATIENT INFORMATION SHALL BE GIVEN TO ANYONE TELEPHONING OR INQUIRING ABOUT A PATIENT OR FORMER PATIENT, INCLUDING SPOUSES, FAMILY MEMBERS, RELATIVES, FRIENDS, EMPLOYERS, AND FORMER PATIENTS, UNLESS A VALID PATIENT CONSENT HAS BEEN OBTAINED.

☐ NO, I DO NOT CONSENT TO RELEASE THE INFORMATION IN MY MEDICAL RECORD.

☐ YES, I HEREBY CONSENT TO RELEASE ANY AND ALL INFORMATION FROM MY MEDICAL RECORD TO:

NAME	RELATIONSHIP

Patient Contact

All calls regarding your health care test results and appointments will be made to your primary phone number. If you would like us to contact you at an alternative phone number, please indicate this number.

Contact Phone Number: (_____)____________________

☐ I hereby authorize this medical practice to contact by phone and if I am not present, you may leave a message on my answering machine/Voicemail.

☐ I prefer that you do NOT leave messages on my answering machine