



Patient Name: \_\_\_\_\_

MR#: \_\_\_\_\_

### Acknowledgement of Receipt

I have been given a copy of Bayview Physicians Group's Notice of Privacy Practices, version effective **September 23, 2013**. I consent to the uses and disclosures of my health information as outlined in the Notice.

### Privacy Options

- I want **NO ONE** to receive my Personal Health Information except myself.
- I request the following person(s) **BE ALLOWED** to access my Personal Health Information:

\_\_\_\_\_

\_\_\_\_\_

- I request the following person(s) **NOT BE ALLOWED** to access my Personal Health Information:

\_\_\_\_\_

\_\_\_\_\_

### Communications

- I give permission to leave a verbal message at my personal residence. \_\_\_ Yes \_\_\_ No
- I give permission to leave a message regarding my appointment on my voicemail. \_\_\_ Yes \_\_\_ No
- I give NowCare permission to release any urgent care notes to my personal physician. \_\_\_ Yes \_\_\_ No
- I give permission to call me at work.      Work Phone: \_\_\_\_\_ \_\_\_ Yes \_\_\_ No

### Please Sign

<b>Patient's Name (Print)</b> Lname, Fname	<b>Patient's Signature</b>	<b>Date</b>
---	----------------------------	-------------

*If you are signing on behalf of the patient, please complete this section:*

<b>Representative's Name (Print)</b>	<b>Representative's Signature</b>	<b>Date</b>
--------------------------------------	-----------------------------------	-------------

**Reason Patient Cannot Sign**

### \*\*\* Office Use Only \*\*\*

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

\_\_\_\_\_

\_\_\_\_\_