ISLAND FAMILY MEDICINE

ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have had an opportunity to review Island Family Medicine's Notice of Privacy Practices.

Patient's Name (Please Print)	**Name of Legal Guardian (Please Print)**
Patient's Signature (Please Sign)	**Signature of Legal Guardian**
Date	**Date**

☐ There are occasions where Island Family Medicine may need to discuss my medical records with a representative designated by me. Please assist with your medical care by appointing one or more representatives below:

__________________________, Relationship __________________ Phone __________________

__________________________, Relationship __________________ Phone __________________

☐ I prefer you not discuss my medical records with anyone but me __________________________
Patient Signature

I give my permission to leave medical information (medication questions, normal test results) on my answering machine:

- ○ Yes
- ○ No

____ ______________
Patient Signature Date

This acknowledgement page will be retained in the patient's record.
If acknowledgement could not be obtained from the patient,
The reasons must be documented below.

____

____