Acknowledgment of Receipt of Notice of Privacy Practices

Center for Functional and Integrative Medicine, Inc.
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I hereby acknowledge that I have read a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

PATIENT RECORD OF DISCLOSURE

Signed: _____ Date: _____

Print name: _____ Phone: _____

Name and Address of Patient:
_____

If not signed by the patient, please indicate relationship:

_____ parent or guardian of minor patient

_____ guardian or conservator of an incompetent patient

I wish to be contacted in the following manner (check all that apply)

☐ O.K. to leave message with detailed information ☐ On answering machine

☐ Leave message for me to call the office ☐ Do not mail to my home address

☐ O.K. to leave message with _____

I authorize this office to release medical information to the following person(s):

_____

_____

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom, Address, Phone #	What and Why Disclosed	Who Sent