Integra Health MD

ACKNOWLEDGE OF RECEIPT OF NOTICE OF COMMUNICATION

I, _____ have read and understand this office's Notice of Privacy Practices.

You have my permission to release medical records/ information to my _____

Who name is: _____

Date: _____

Signature: _____

FOR OFFICIAL USE ONLY

We attempted to obtain acknowledgement pf our Notice of Privacy Practices, but it could not be obtained because:

_____ Patient Refuse to sign
_____ Communication Barriers
_____ An emergency
_____ Other: _____

Integra Health MD

ACKNOWLEDGE OF RECEIPT OF NOTICE OF COMMUNICATION

I, _____ Authorized Integra Health MD to communicate and confirm my appointments, cancellations, and confirmation.

by email: _____

Phone: _____

Text MSM, to my cell phone number: _____

My Address: _____

I understand that some charges might be incurred by the carriers.

Signature: _____ Date: _____