

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This office of **Colin D. Pero, MD**, is required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

\_\_\_\_\_  
*Patient Name (Please print)*

\_\_\_\_\_  
*Date of birth*

**Which of the following methods do we have permission to contact or leave messages for you regarding your appointments, medication, promotional events or financial information?**

\_\_\_\_\_ Home \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ Cell \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ Work \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ Email: \_\_\_\_\_

\_\_\_\_\_ Home address: \_\_\_\_\_

**Other than your insurance carrier and primary physician, whom may we talk to about your healthcare information?**

\_\_\_\_\_ Spouse Name \_\_\_\_\_ Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ Child Name \_\_\_\_\_ Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ Child Name \_\_\_\_\_ Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ Parent Name \_\_\_\_\_ Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ Other Name \_\_\_\_\_ Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**I acknowledge that I have received a copy of this office's Notice of Privacy Practices and I have had an opportunity to review it.**

\_\_\_\_\_  
*Signature of Patient or Guardian*

\_\_\_\_\_  
*Date*

### FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other *(Please provide specific details)*

\_\_\_\_\_  
Employee signature

\_\_\_\_\_  
Date