

HIPPA ACKNOWLEDGEMENT

I, _____, acknowledge that I have reviewed a copy of **Surgical Group of Johnson City, MPC** notice regarding Privacy of Personal Health Information and have been advised that a copy is available upon request.

Signature

Date

CONTACT INFORMATION

I, _____, give my permission for the Practice of **Surgical Group of Johnson City, MPC**, including the staff, to contact me at the following telephone numbers. Please fill in the telephone numbers including area codes accordingly and initial beside each entry on the black provided.

Home Phone #: _____ Patient Initials: _____

Work #: _____ Patient Initials: _____

Cell #: _____ Patient Initials: _____

Family Members #: _____ Patient Initials: _____

Pharmacy Name #: _____ Patient Initials: _____

Pharmacy #: _____ Patient Initials: _____

Do we have your permission to leave a message with anyone other than you?

Yes _____ No _____ Name _____

Name _____

May we leave a message on your answering machine?

Yes _____ No _____

May we call and / or leave a message to return our call only at your place of employment?

Yes _____ No _____

Signature of Patient

Date

Signature of Witness

Date