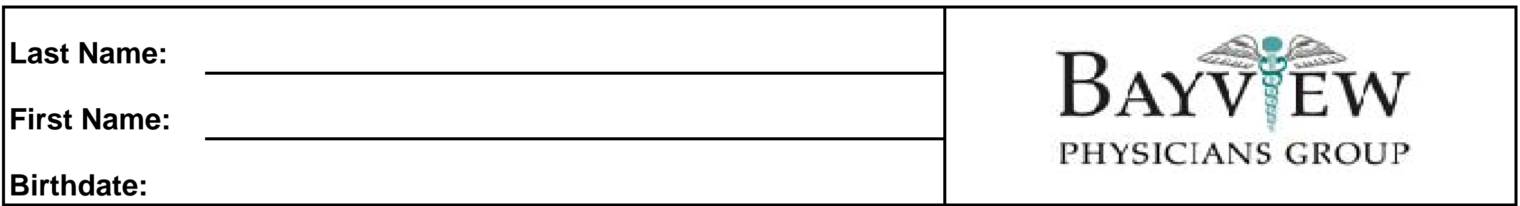

Last Name: ______________________

First Name: ______________________

Birthdate:

Acknowledgement of Receipt

I have been given a copy of Bayview Physicians Group's Notice of Privacy Practices, version effective **September 23, 2013**. I consent to the uses and disclosures of my health information as outlined in the Notice.

Privacy Options

☐ **I want NO ONE to receive my Personal Health Information except myself.**

☐ **I request the following person(s) BE ALLOWED to access my Personal Health Information:**

______________________ ______________________

______________________ ______________________

☐ **I request the following person(s) NOT BE ALLOWED to access my Personal Health Information:**

______________________ ______________________

______________________ ______________________

Communications

I give permission to leave a verbal message at my personal residence.	____ **Yes**	____ **No**
I give permission to leave a message regarding my appointment on my voicemail.	____ **Yes**	____ **No**
I give NowCare permission to release any urgent care notes to my personal physician.	____ **Yes**	____ **No**
I give permission to call me at work. Work Phone: ______________________	____ **Yes**	____ **No**

Please Sign

Patient's Name (Print)	Patient's Signature	Date
Lname, Fname		

If you are signing on behalf of the patient, please complete this section:

Representative's Name (Print)	***Representative's Signature***	***Date***

Reason Patient Cannot Sign

*** Office Use Only ***

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it: