Center for Holistic Medicine
9 Brookwood Avenue, Carlisle, PA 17015
(717) 243-0616 Fax: (717) 245-2351

Name: ___________________________ Date:___________________________

Phone: ___________________________ DOB: ___________________________

Center for Holistic Medicine

PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Acknowledgement of receipt of *Privacy Practices Notice*:

I,___________________________, acknowledge that I have received a Privacy Practices Notice from **Center for Holistic Medicine**.

Patient Signature: ____________________ **Date:** ______________________________

- **I give authorization to release information to the following people:**
  ______________________________ Relationship: _________________
  ______________________________ Relationship: _________________

- **May we leave a message on an answering machine or with your spouse? Y/N**

- **May we use Email to communicate with other medical professionals? Y/N**

- **If a personal representative on behalf of the individual signs this authorization please complete the following:**

Personal Representative's Name: ____

Relationship to Individual: ____

Signature Office Representative (office use only):

I attest that the above information is correct.

Signature: ____________________________ Date: ______________________________

Print Name: ___________________________ Title: ______________________________