Notice of Privacy Practices Acknowledgement Form

Part A

Name: ______________________ Date: ______________________

By signing below, I attest I have received and understand MyCare's Notice of Privacy Practices.

______________________ ______________________
Signature Date

If signed by parent or legal guardian:

Name: ______________________ Relationship to Patient: ______________________

Part B

I consent to be contacted regarding appointment and medical information by the following methods. *Mark all that apply.*

METHOD	CONTACT NUMBER/INFORMATION	
☐ Text Message		
Message & data rates may apply. You can STOP messaging by sending STOP and get more HELP by sending HELP.		
☐ Email		
☐ Cell Phone (Call)		Can we leave a message (Y/N):
☐ Home Phone (Call)		Can we leave a message (Y/N):
☐ Work Phone (Call)		Can we leave a message (Y/N):

Part C

Who can we share medical information with?

Name	Contact Information	Relationship

Office Use Only

We attempted to obtain acknowledgment of receipt of our Notice of Privacy Practices, but was not be obtained because:

☐ Declined to sign ☐ Emergency Care Provided

☐ Other