Pacific Grove Family Medicine, Inc.
621 Forest Avenue
Pacific Grove, CA 93950
Tel : 831-649-1011 Fax : 831-373-8201

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient: ____

I, _________________________________ (print name) hereby acknowledge that a copy of the Notice of Privacy Practices (HIPAA) is available upon request.

Signed: ____ Date: ______________________

If not signed by the patient, please indicate signer's relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary of personal representative of deceased patient

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Authorization to Discuss Health Information

I, _________________________________ (print name) authorize the office of Pacific Grove Family Medicine to discuss my health information with the following person(s):

_______________________________________ _________________________________
Name Relationship

_______________________________________ _________________________________
Name Relationship

I do _____ / do not _____ authorize the physicians & staff of Pacific Grove Family Medicine to leave voicemail messages containing health information at the following phone numbers:

_______________________________________ _________________________________
Cell Home

____
Signature Date