Pacific Grove Family Medicine, Inc.
621 Forest Avenue
Pacific Grove, CA 93950
Tel : 831-649-1011   Fax : 831-920-4506

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

– –

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