Acknowledgement of Receipt of Notice of Privacy Practices

Shoreline Medical Associates, LLC
1353 Boston Post Rd.
Madison, CT 06443
203/245-4933

Name of Patient: ______________________________ **Birthdate:** ___________

I hereby acknowledge that I received a copy of Shoreline Medical Associates, LLC Notice of Privacy Practices. I will receive a new copy of the Notice of Privacy Practices at my next appointment following any amendments to the notice.

Signed: ________________________________ **Date:** _________________

If not signed by the patient, please indicate your relationship to the patient:

____

I authorize Shoreline Medical Associates to **release or speak to** the name(s) listed below regarding my personal health information (example: **spouse, relative, friend or no one)**

Name(s):____

____

Relationship to patient:

____

(PLEASE CHECK ALL THAT APPLY)

____ Call my home/cell phone and if necessary leave a message on the answering machine/voice mail/ with **a family member** for me to call back to schedule an appointment or to return your call.

____Call my home/cell phone and if necessary leave a message on the answering machine/voice mail/with **a family member** giving the results of any test.

____ Call my home phone and **only** speak to **me** or leave a message/voice mail on **my** cell phone voice mail regarding appointments, test results, etc. Do not speak or leave a message with anyone but myself.

Signature: ______________________________________Date:________________