Pulmonary Consultants & Primary Care Physicians Medical Group, Inc.

Notice of Privacy Practices Acknowledgement

HIPAA (Health Insurance Portability and Accountability Act) regulations require us to provide to you, the patient or personal representative, a copy of our Notice of Privacy Practice and for you to sign as acknowledging receipt of this brochure.

Patient Name____

Patient Representative ____________________________________

Signature ____

Date ____

AUTHORIZATION TO LEAVE MESSAGES

I authorize Pulmonary Consultants to leave messages regarding my protected health information (PHI) on my telephone answering machine or with a family member or other designated party.

Pulmonary Consultants may share information about my condition with:

____

Name Relationship Telephone Number

____

Name Relationship Telephone Number

Telephone answering machine number___________________________

Signature ____

Date ____

OFFICE USE ONLY

I attempted to obtain the signature of the patient or patient's representative acknowledging the receipt of the "Notice of Privacy Practices" for Pulmonary Consultants & Primary Care Physicians Medical Group, Inc., but was unable to do so, as documented below:

Date:	Initials:	Reason: