Written Acknowledgement Form

Patient Name ____ Chart # ________________________

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I, _______________________________ (please print patient name), have received a copy of VCS's Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions of VCS if I do not understand any information contained in the Notice of Privacy Practices.

Please allow the following people to have access to my Medical Records (e.g., list name of spouse, parents, children, etc.):

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VCS staff has my permission to leave test results on my home answering machine and/or cell phone voice-mail.

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Phone number

____
Second phone number

____
Patient signature

____
Date

____
Patient signature

____
Date

____
Authorized representative of patient

____
Relationship to patient

____
Date