**Notice Of Privacy Practices - Acknowledgement**

We keep a record of the health care services we provide you. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

Our Notice Of Privacy Practices describes in more detail how health information may be used and disclosed, and how you can access your information.

You authorize the medical facility to: Please check the numbers(s)

1. Send you a recall post card remind you it is time to make another appointment.

2. Permission to call and remind you of your appointment time with Dr. Geisse, if you

are not home we can leave the message on your answering machine.

\_\_\_\_\_\_3. Permission to contact any other treating physicians regarding my medical care.

4. Only disclose your medical history with the following persons.

1. Spouse – Name
2. Children – Name
3. Friend – Name
4. Brother / Sister – Name
5. Friend – Name
6. Parent; Grandparent – Name
7. Care Giver; Nursing Home – Name
8. Interpreter / Lawyer – Name
9. Other – Name

By my signature below I acknowledge receipt of the entire Notice Of Privacy Practices.

Patient or legally authorized individual signature Date Time

Printed name of person who is signing the form Relationship (Patient, Parent, Legal guardian)

(Notation, if any, by staff)