Island Family Medicine, PLLC

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ACKNOWLEDGEMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have had an opportunity to review Island Family Medicine's Notice of Privacy Practices.

Patient Name: (Please Print)	Name of Legal Guardian (Please Print)
Patient's Signature (Please sign)	Signature of Legal Guardian (Please sign)
Date:	Date:

☐ There are occasions where Island Family Medicine may need to discuss my medical records with a representative designated by me. Please assist with your medical care by appointing one or more representatives below:

Representative #1 _____, Relationship _____ Phone: _____

Representative #2 _____, Relationship _____ Phone: _____

☐ I prefer you not discuss my medical records with anyone but me _____
(Patient Signature)

I give my permission to leave medical information (i.e medical questions, lab results, etc) on my voicemail.

☐ Yes ☐ No Best # to Contact you: _____

I give my permission for you to send medical information (i.e. medical questions, lab results, etc) via electronic mail.

☐ Yes ☐ No Email Address: _____

Patient Signature: _____ Date: _____

Island Family Medicine does not sell or share personal information with third parties for marketing/promotional purposes. Mobile information will not be shared, sold, or conveyed to third parties for marketing/promotional purposes.
This acknowledgement page will be retained in the patient's record. If acknowledgement could not be obtained from the patient, the reason must be documented below: