Gulf Coast Pulmonary and Sleep

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES:

** You may refuse to sign this acknowledgement**

I have received a copy and/or been offered a copy to review of this offices "Notice of Privacy Practices."

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Authorizations

__Yes
__ No I hereby authorize you to leave medical information (appointment dates, times, prescription information) on my answering machine at home or my cell phone

__ Yes
__ No I hereby authorize you to call me at work

For office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sigh

__ Communications barrier prohibited obtaining the acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (Please Specify)

_____

_____