I authorize The Center for Medical Weight Loss to do the following:

1. Leave test results on my answering machine or voice mail: Yes____ No____

2. Give test results to another person at my telephone number: Yes____ No____

Acknowledgement of Receipt

I have received, read and understand your **Notice of Privacy Practices.**

Patient Name (print): _____

Patient Signature: X_____

Effective Date: **April 14, 2003** Date of Visit: ____/____/____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this **Notice of Privacy Practices,** but was unable to do so as documented below:

_____
_____
_____

Date: ____/____/____ Initials: _____