CHANDLER ENDOCRINOLOGY

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RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing this acknowledgment of Receipt of Notice of Privacy Practices (the "Notice"), I acknowledge and agree that I have received, read and understand the Notice of Privacy Practices and if I choose I can keep a copy for my records on the date identified below. I understand that Chandler Endocrinology may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, exam information and/or type of products provided) to another party to permit Chandler Endocrinology to perform its administrative duties, provide me with medical care services and products, process my claims and communicate with me regarding medical care services provided by Chandler Endocrinology. I can be assured that this location does not sell my personal health information of any kind to a third party for such party's own use. I authorize the Location to submit my medical benefit claims to my plan sponsor or health plan to receive reimbursement directly for the medical services and products that I have received from Chandler Endocrinology.

_____ _____
Signature of Patient or Legal Guardian Date

PHONE MESSAGE CONSENT

In an effort to protect your privacy, our policy on leaving medical information is:

- We will NOT leave detailed messages with anyone except the authorized person or legal guardian.
- We will NOT leave any confidential information on an answering machine.
- We will NOT leave any messages with parents if you are over the age of 18.

UNLESS

WE HAVE YOUR WRITTEN PERMISSION TO DO SO

Please read below and list whom you authorize if anyone to have access to protected health information.

I, _____ give Chandler Endocrinology my permission to speak with and/or leave messages regarding my medical care and/or billing with the following. I fully understand that this consent will remain valid until revoked in writing.

☐ I do not authorize any detailed VoiceMails to be left. Only leave message for return call. Initials:_____

☐ Ok to leave detailed messages on:
My Home/Cell VoiceMail: # _____ Initials: _____
My Office/Work VoiceMail: # _____ Initials: _____

I also authorize the following people/person to receive information regarding my Healthcare and/or billing.

Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship:_____

Phone: _____

Name: _____ Relationship: _____

Phone: _____
This form is not to release medical records. If records need to be sent to another physician or obtained by me I understand I will have to fill out an actual medical records release.

Patient Signature: _____ Date: _____