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# Family Medical Center

## Acknowledgment of Receipt of Notice of Privacy Practices

**Privacy-officer - Office- Manager - 949-363-5322**

I hereby acknowledge that I received a copy of this medical practice's Notice of Private Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Private Practice at each appointment.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Type of PHI to be restricted or limited: (Please check all that apply):

- No restrictions
- Restrictions-Please check below for the restrictions:

Home address  
Home Phone  
Lab results  
Office address/

Office phone  
Prescriptions information  
U.S./X-ray Reports  
Visit Notes

Voice Mail home  
Voice mail work  
Other \_\_\_\_\_

If not signed by the patient, please indicate

- Patient or guardian of a minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

We do not release any records/Information to any of the contact telephone numbers given unless specified.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

