Acknowledgement of Receipt of Notice of Privacy Practices

Island Medicine
Lorraine F. Burns, MD Privacy Official, 631-757-9500

Name of Patient:_____

Telephone:_____

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

I realize that it is sometimes necessary for this medical office to contact me regarding my Personal Medical Information. Since it can sometimes be very difficult to contact me directly, I authorize Island Medicine to discreetly leave information on my home answering machine. In addition, the following individuals may receive my Personal Medical Information on my behalf.

__Spouse_____
__Parent_____
__Child_____
__Friend_____
__Other_____(please specify)

Signed_____
Date:_____
If not signed by the patient, please print name and indicate you relationship to the patient:

For Office Use Only:

Signed form received by:_____
Acknowledgement refuse:_____
Efforts to obtain:_____
Reasons for refusal:_____