FINEGOLD PRIMARY CARE
RICHARD D. FINEGOLD, M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & OFFICE POLICIES

Finegold Primary Care is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Finegold Primary Care and Office Policies.

Name: ____

Signature: ____

Name of Personal Representative (if appropriate):

____

Signature of Personal Representative (if appropriate):

____

Date: ______________________

Phone: You may contact me by phone at: ______________________

Leave messages on answering machine: _____ yes _____ no

Leave messages with any other person: ____ yes ____ no

Other requests for confidential communications:

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Signed: ______________________________ **Date:** ______________

Finegold Primary Care use only:

Date acknowledgement received: ________________ Initials: ______________

- OR –

Reason acknowledgement was not obtained:

______________________________________ Initials: ______________