PRIMARY CARE ASSOCIATAES, P.S.
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may request and obtain a copy of that record. You may also ask to correct that record. We will not disclose that record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your records to get more information about it by contacting Primary Care Associates, PS.

Our Notice of Privacy Practices posted in the reception describes in more detail how your health information may be used and disclosed and how you can access your information.

By my signature below I acknowledge being informed of the above privacy policies.

_____ _____

Patient or legally authorized individual Signature **Date**

_____ _____

Printed name if signed on behalf of patient **Relationship**

CONSENT TO LEAVE MESSAGES

We at Primary Care Associates are working to insure the confidentiality regarding your Protective Health Information and care is maintained at all times. Due to confidentiality concerns and to comply with the HIPAA act of 1996, we need your signature to allow us to leave a message about your upcoming office visit, account information, and/or any test results you may want us to convey to you via telephone or electronic messaging.

Please complete and sign this form indicating you preference.

I _____ give Primary Care Associates permission to :

☐ **Leave a message regarding my upcoming office visit, account information, and test results on my home phone or cell phone. ( )**

☐ **Leave a message with spouse or other person named below who answers the phone at my residence. ( )**

☐ **Leave a message at my place of employment. ( )**

_____ _____

Patient Signature ***Date***