

*Seven Hills Medical Arts, Inc.*

**Notice of Privacy Practices for Protected Health Information**  
**(PHI)**

**Acknowledgment of Receipt of Notice of Privacy Practices**  
**(NPP)**

I, \_\_\_\_\_, have received the Practice's NPP and understand that my PHI may be used and/or disclosed by the practice as described in the Notice.

By checking one of the lines below, you authorize the Practice to disclose information (or restrict any such disclosures). The Practice may:

Leave information on my answering machine(s) or voice mail(s)

Leave information with anyone who answers my home, mobile, office, or other telephone number(s)

My PHI can be left/discussed with the following: \_\_\_\_\_

\_\_\_\_\_

Do not give/leave information with anyone other than myself (this will exclude your information from spouses, significant others, parents, children, and any other family member)

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient of personal representative