



Acknowledgment of Privacy Practices and Permission to Leave Messages.

Patient Name: _____ Date of Birth: _____

I acknowledge that I have received and/or reviewed a copy of MyDoctor LLC Notice of Privacy Practices

I give permission to communicate messages in the following manner:

____ You may leave a message on my answering machine located at this number _____

____ You may leave a message on my cell phone _____

____ You may leave a message with my spouse, _____ at this number _____

____ You may leave a message with another person, _____ at this number _____

I give permission to communicate messages about the following:

____ Labs, x-rays, and other test results

____ Prescriptions

____ Billing or insurance matters

Patient Name

Date

Last updated July 29, 2009