

NORTH COAST FAMILY MEDICAL GROUP

Acknowledgement of Privacy Practices

By signing this form I acknowledge that I have received a copy of the North Coast Family Medical Group Notice of Privacy Practices. I also give North Coast Family Medical Group permission to contact me regarding my personal healthcare including but not limited to: medical evaluation and treatment, prescriptions, test results, medical records information, appointment scheduling and reminders, and billing issues.

Please complete this from indicating the best ways for our office to contact you regarding the issues listed above.

I, _____ request to be contacted at the following phone numbers:

Home: () _____
May we leave messages? Yes No

Cell:() _____
May we leave messages? Yes No

Work: () _____
May we leave messages? Yes No

Other: () _____
May we leave messages? Yes No

Please list any persons that we may leave messages with:

Please list any persons that you would like to have access to any and all of your medical information and treatment (family members, spouses, Parents, children):

Name: _____ Relationship: _____

Phone #: _____ Alternate phone #: _____

Name: _____ Relationship: _____

Phone #: _____ Alternate phone #: _____

North Coast Family Medical Group may also contact me by:

_____ **Mail.** My address is: _____

_____ **E-Mail.** My e-mail address is: _____

Preferred Pharmacy – This is the pharmacy we will fax prescriptions to.

_____ North Coast Family Medical Group may speak to my pharmacy regarding any prescriptions provided by our office.

Pharmacy Name and Address: _____

Patient Name: _____ **Date:** _____

Signature of Patient or Legal Guardian: _____

Print Patient or Legal Guardian Name: _____