AMY BRENNER, MD & ASSOCIATES

NOTICE OF PRIVACY PRACTICES RECEIPT ACKNOWLEDGMENT

We are required to provide you with a copy of our NOTICE OF PRIVACY PRACTICES when you receive care at Amy Brenner, MD & Associates.

Patient or Patient's Legal Representative: Please check the appropriate box and sign.

I do not want a copy of the Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices

DISCLOSURE TO FAMILY/FRIENDS

I hereby authorize Amy Brenner & Associates, to discuss the following with the person/persons listed below:

Condition/Treatment/Plan of Care Diagnostic Test Results Lab Results

Authorized person/persons:

Name Relationship

_____ _____

_____ _____

PERMISSION TO COMMUNCIATE AND/OR LEAVE A DETAILED MESSAGES, PLEASE CIRCLE ALL THAT APPLY:

1. HOME PH#_____
2. WORK PH#_____
3. CELL PHONE PH#_____
4. TEXT MESSAGE* PH#_____
5. EMAIL* EMAIL_____

Patient's Name or Legal Representative:_____

Patient's DOB :_____ Patient's Name (Print): _____

Signature:_____ Date:_____

It is important that we understand the scope of authority you have to act on behalf of the patient. Please provide the

appropriate documentation for guardianship, executor/executrix of estate, or power of attorney.

*These messages are not sent encrypted

****If changes are required, a new form must be completed by the patient****