Lakeland Medical Associates

Providing Care for the Entire Family Since 1995

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Furthermore, I authorize my physician and his/her staff, to contact me by the designated means noted below.

Home Phone: _____ *Circle One:* Call only / Call & Voicemail
Work Phone: _____ *Circle One:* Call only / Call & Voicemail
Cell Phone: _____ *Circle One:* Call only / Call & Voicemail
Email/Patient Portal: _____

Additionally, I authorize my physician and his/her staff, to communicate information regarding appointments, medical results and billing issue to the following person(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

This Authorization shall remain in force until revoked in writing, Attention of Privacy Officer.

Patient/Representative Signature: _____ **Date:** _____
**If not signed by Patient,* Name of Authorized Representative:_____
Relationship to Patient: __Parent/Guardian __POA __Other:_____