ACCESS MEDICAL CLINIC
FAMILY PRACTICE

Notice of Privacy Practices
Acknowledgement of Receipt

_____ I have been offered a copy of Access Medical Clinic's Notice of Privacy Practices.

Release of Medical Information

I,_____, give **Access Medical Clinic** permission to release information regarding my medical care and to discuss my account with the following individuals:

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____I authorize **Access Medical Clinic** to leave protected health information on my home answering machine/voice mail, if I am not available.

Patient Name_____ Date of Birth_____

Patient Signature_____ Date_____

Witness_____ Date_____

Please notify Access Medical Clinic of any change of contact person(s) or revocation of authorization concerning your Patient Medical Information.

If you feel there has been a breach of your medical history, please contact any of our clinic locations an notify them immediately.