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Acknowledgement of Receipt of Privacy Notice

I acknowledge that I have received a copy of Dr. C. Steven Plimpton's Notice of Privacy Practices. This notice describes how our office may use and disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information.

I authorize DR. Plimpton's office to leave messages on my answering machine, e-mail and/or voice mail.

Yes No

In accordance with the privacy policy, I authorize Dr. Plimpton's office to disclose information relative to my care to the following individuals (please print)

Signed: _____ Date_____

please print name: _____