Acknowledgement of Receipt of HIPAA

I acknowledge that I have received a copy of James S. Linder, M.D.'s Patient Agreement including the Notice of Privacy Practices For Protected Health Information. I have been given an opportunity to ask questions about this agreement and the privacy practices described therein.

I agree to be bound by the terms of this agreement except for those areas listed below.

I understand that I may revoke this agreement at any time in writing. Such revocation will be effective when received by the practice and will not be effective for any privacy disclosure previously made under the terms of the agreement or for any payment obligations for services already rendered.

- **In the event that you do not answer we will leave a message concerning appointments or other health information on your answering machine or with the adults you list below unless you specify differently.**

- **Is it OK to leave a message on your answering machine or with the person(s) listed below regarding your health information? ☐ Yes ☐ No**

- **Is it OK to get your medication history from your pharmacy? ☐ Yes ☐ No**

Please provide us with all the names of family, friends, and/or physicians that have permission to receive your health information and/or appointment information on your behalf:

Name_____ **Relation**_____

Name_____ **Relation**_____

Name_____ **Relation**_____

Please list any restrictions on the use of your protected health information:

_____

Signature: _____

Printed Name: _____

Date: _____