

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed (or been offered the opportunity to review) this office's Notice of Privacy Practices, which explains how Suzanne Weakley, MD will use and disclose my medical information. I understand that I am entitled to receive a copy of this document.

I authorize the office of Dr. Suzanne Weakley to leave messages regarding appointments and/or lab results at the following locations:

Home telephone or family member: Yes No N/A

Home Answering machine: Yes No N/A

Work Phone or Voicemail: Yes No N/A

Cell Phone: Yes No N/A

Other Phone/email/contact: (please provide information below)

Other Instructions:

Signature of Patient **OR** Personal Representative

Name of Patient **OR** Personal Representative

Relationship to patient

Date