



NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

I have received a copy of Advanced Breast Care's Notice of Privacy Practices. I understand that Advanced Breast Care has the right to change its Notice of Privacy Practices from time to time and that I may contact Advanced Breast Care at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name (print) _____

Signature of patient / Legal Representative _____

Relationship to Patient _____

PATIENT CONFIDENTIALLY STATEMENT: Patient confidentiality is our top priority at Advanced Breast Care. It is our goal to provide each patient with complete privacy concerning their medical records, medical history and future medical appointments. It is important that you provide us with the following information to protect your privacy.

In the event that I, _____, am unable to be reached regarding appointment, rescheduled appointments, lab or surgery results, Advanced Breast Care may leave information with the following:

Spouse (Name) _____

Children (Names) _____

I may be reached at work: Telephone _____

May leave message at work.

May leave normal results on answering machine/voice mail

Other (Describe) _____

Please specify if there are any other family members who may obtain or call to discuss your medical information.

Signature

Date
