

ACKNOWLEDGEMENT OF RECEIPT

I, _____, hereby acknowledge that PDA has given me the opportunity to read a detailed notice of their Privacy Practices.

Patient / Guarantor Signature * _____ Date _____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

If not signed, please provide a reason why the acknowledgement was not obtained.

Witness _____ Date _____

Staff Signature

CONSENT TO RELEASE INFORMATION

In the event I cannot be reached, I, _____, give permission for a representative from PDA, to speak with family member (s) or companion (s) listed below regarding care or tests results.

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

Is it OK to leave results or information on your voicemail? _____ Yes _____ No

Patient / Guarantor Signature * _____ Date _____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

CONSENT TO CORRESPOND ELECTRONICALLY

While PDA takes reasonable precautions to protect your confidential information, email is not a completely secure method of communication.

I acknowledge that if I use electronic mail to initiate contact with a PDA physician regarding my medical care, that PDA physician and /or his/her representative has my permission to correspond via that email address.

I give permission for a PDA physician or clinical staff member to email me at

_____ @ _____ regarding my medical care.

Patient / Guarantor Signature * _____ Date _____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.