VIRTUA ENDOCRINOLOGY

Patient Name: ___________________________________ Date of Birth: ____________
(Please Print)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

By signing below, I acknowledge receipt of the Notice of Privacy Practices of Virtua Endocrinology. In addition, by signing below, I authorize Virtua Endocrinology to disclose my health information in conformance with the provisions of the Notice of Privacy Practices.

Signature: _______________________________________ Date: __________________

Phone Authorization

_____ ***Yes, you have my permission to leave medical information on my answering machine. Please let us know which daytime telephone number is best to do so. (   ) _______________________.***

_____ ***No, you do not have my permission to leave medical information on my answering machine.***

Signature: ____ Date: ____________

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, indicate the reason why the acknowledgement was not obtained.

_____ Individual refused to sign

_____ An emergency situation prevented us from obtaining the acknowledgement

Signature of Virtua Representative: ____

Date: __________________