

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

By signing this form, you acknowledge that Dr. Bryman’s office has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations.

Check all that are true:

- I have received Dr. Bryman’s Privacy Notice.
- Dr. Bryman** has given me the chance to discuss my concerns and questions about the privacy of my health information.
- I have been given the opportunity to restrict disclosure of my information.

**May we contact you via any of the following methods about appointments, treatment, billing, promotions or other matters relating to the program? (Please circle.)**

<b>Call you at home?</b>	<b>Yes</b>	<b>No</b>	<b>Leave a message at home?</b>	<b>Yes</b>	<b>No</b>
<b>Call you at work?</b>	<b>Yes</b>	<b>No</b>	<b>Leave a message at work?</b>	<b>Yes</b>	<b>No</b>
<b>Call you on your cell?</b>	<b>Yes</b>	<b>No</b>	<b>Leave a message on cell?</b>	<b>Yes</b>	<b>No</b>
<b>Send you e-mail at the address provided?</b>	<b>Yes</b>	<b>No</b>			
<b>Send mail to you at home to the address provided?</b>	<b>Yes</b>	<b>No</b>			

**If there are any individuals with whom we are permitted to share your medical information, please provide their name(s) here:** \_\_\_\_\_

\_\_\_\_\_  
Patient’s Signature

\_\_\_\_\_  
Date

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*Office use only:*

Complete if Acknowledgement Form is not signed:

Does patient have a copy of the Privacy Notice?

[ ] Yes      [ ] No

Please explain why the patient was unable to sign an acknowledgement form and Dr. Bryman’s efforts in trying to obtain the patient’s signature:

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