Acknowledgement of Notice of privacy practices

Notice to Patient:

Advanced Internal Medicine is required to provide you a copy of our Notice of Privacy Practices, which states how Advanced Internal Medicine may use and/or disclose your health information at your request.

Please list below any person(s) that you approve for your information to be released to. This will allow the person(s) listed access to your medication information, including, but not limited to appointments, diagnosis, and/or treatments that you have discussed with your physician. You many list as many person's as needed or may request that your information not be released to any other individual. Should you decide that no one be listed, we may not be able to answer any questions regarding your care with anyone other than yourself.

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

I acknowledge that I have been offered a copy of Advanced Internal Medicine's Notice of Privacy Practices and that the person(s) listed above are individuals to whom you can share my information.

_____ _____

Patient's Name (printed) **Today's Date**

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Patient's Signature