Acknowlegemnet of Receipt of Notice of Privacy Practice

Susie M, Privacy Officer (805) 983-1700

As required by the Health Information Portability and Accountability Act of 1996 (HIPPA) and California Law, you have the right to request that communications concerning your personal health information be made through confidential channels. Also, this practice may not use or disclose your individually identifiable health insurance except as provided in our Notice of Privacy Practice without your individually indentifiable health insurance except as provided in our Notice Privacy Practice without your authorization. Your completion of this form means that you are giving permission for use and disclosure described below. Please review and complete this form carefully.

I hereby request to be contacted in the following confidental manner:

(Please select all that apply)

☐ Home: ____

☐ Cell Phone: ____

☐ Work Phone: _______________________________________

☐ Other: ____

☐Do Do Not☐ Leave messages on answering machine

☐Do Do Not☐ Leave messages with any other person

Please **Do / Do Not** release confidental information to: (circle one)

Name: ______________________________________

Relationship: ____

I acknowledge that I was offered a copy of this medical practice's Notice of Privacy Practice.

Signed:____ Date: ______________

Print Name: ____