Gregory O Dick, M.D., FACS
Shirley A' Olsen, M.D.
Plastic & Reconstructive Surgery

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Patient Name:_____**Date:** _____

By signing this form, you acknowledge that Gregory O. Dick, M.D., FACS / Shirley A. Olsen, M.D., have provided you access to a copy of it's Privacy Notice, which explains how your health information will be handled in various situations. By law, we are required to have you sign this form on your first date of service with us.

If your first date of service with us was due to an emergency, we will provide you with access to this notice and have you sign this form as soon as possible.

Please specify by checking the appropriate answer below if we may leave health related information, (i.e., Lab or X-ray results, Billing issues, or any other Doctor-Patient communications), on your:

Cell Voicemail: _____ **Yes** _____ **No** **Home Voicemail:** _____ **Yes** _____ **No**

Work Voicemail: _____ **Yes** _____ **No** **Email:** _____ **Yes** _____ **No**

*******Please note that if the above section is not completed, we will assume that we have your approval to contact you using any of these methods.******

You may release my medical information to the person or persons listed below:

Name: _____

Relationship: _____ **Phone:** _____

The Practice has provided me access to it's Privacy Notice. I understand I may request a copy for my personal use.

I acknowledge that I have read, understand and agree to the above.

_____

Patient or Representative Signature

Updated 8/16