

## Acknowledgement of Receipt of Notice of Privacy Practice

Annapolis Hand Center LLC reserves the right to modify practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Annapolis Hand Center LLC.

\_\_\_\_\_  
Name of Patient (Print or Type)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative  
(required if the patient is a minor or an  
Adult unable to sign this form).

\_\_\_\_\_  
Relationship of Patient Representative to the  
patient.

\_\_\_\_\_ Patient declined to sign the acknowledgement.

---

### Release of Medical Information

I authorize the release of information including diagnosis, records, examination rendered to me & claims information. This will also allow pick up of prescriptions. This information may be released to

Spouse \_\_\_\_\_

Child(ren) \_\_\_\_\_

Other \_\_\_\_\_

Information is not to be released to anyone.

### Messages

Please call  my home  my work  my cell

If unable to reach me

you may leave a detailed message

please leave a message asking me to return your call

\_\_\_\_\_

I consent to receiving non-encrypted email from office staff.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_