ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Dr. Gregg A. Feinerman's Notice of Privacy Practices. This notice describes how Dr. Gregg A. Feinerman may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Print Patient Name:

_____

Signature of Patient or Personal Representative:

_____

Date: _____

Relationship to Patient (please check one):

_____ Patient _____ Parent or Guardian _____ Other: _____

In general, the HIPAA Privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

_____ Home Telephone: _____

_____ OK to leave message with detailed information

_____ Leave messages with call-back number only

_____ Work Telephone: _____

_____ Ok to leave message with detailed information

_____ Leave message with call-back number only

_____ Written Communication

_____ OK to mail to my home address

_____ OK to mail to my work/office address

_____ OK to fax to this number: _____

_____ Other:

_____

_____