ICPR Family Practice

Care • Prevent • Rejuvenate.

Notice of Privacy Practices Acknowledgement
ICPR Family Practice

I have been presented with a copy of the Notice of Privacy Practices which explains how my health information may be used and disclosed as permitted under the federal and state law, and outlines my rights regarding my health information.

I wish to have the following restriction on disclosure of health information: _____
_____
_____.

_____
Initials

I authorize the physicians and staff of ICPR Family Practice to release of information about my medical condition to the following person(s).

Name: _____Ph#_____Relationship: _____
Name: _____Ph#_____Relationship: _____
Name: _____Ph#_____Relationship: _____

_____
Initials

☐ I authorize a representative of ICPR to leave a message regarding upcoming appointments on the answering machine at my home.

☐ I agree to have appointment reminders e-mailed to the following address:

_____

_____
Initials

Signed: _____ Date _____

Relationship (*If not signed by patient*) _____

ICPR Witness: _____