ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

Dr. Major's office has a Privacy Policy which explains how your medical information will be used, disclosed and protected. By signing below, you acknowledge that our office has a Privacy Policy and you understand that you are entitled to receive a copy of this document upon request.

At times, we will need to contact you regarding your health care. What is the best method to reach you?

1. May we leave a message about your health information on your home phone? Yes or No
   Home phone number ______________________________
2. May we leave a message about your health information on your cell phone ? Yes or No
   Cell phone number ______________________________
3. Email: ______________________________

Also, you may request that we disclose your private health information to family members, other relatives or close personal friends. If you wish to do so, please list their names and numbers.

1.______________________________

2.______________________________

3.______________________________

____
Signature of Patient or Personal Representative

____
Date