ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Salem Chest Specialists Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice.

I understand that I have the right to request restrictions concerning the use of my information. I request the following restrictions:

_____

_____

With whom we may discuss your treatment other than your physicians?

Name: _____ *Relationship:* _____ *Phone:*_____

Name: _____ *Relationship:* _____ *Phone:*_____

With whom may we discuss your payment (if different from above)?

Name(s): _____

Signature: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient:

Relationship: _____ *Witnessed by:* _____

INTERNAL USE ONLY

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on: _____ _____
Date *Time*

By: _____
Name and Title