

Mid-Atlantic Family Medicine

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By signing below I, _____, acknowledge that I have been offered the Privacy Rights Information as required by HIPAA.

I give my permission to have messages left on my answering machine regarding medical information such as appointment information, laboratory results, and/or prescription information.

_____ yes _____ no

Phone number: _____

I give my permission to be contacted by email. _____ yes _____ no

Email address: _____

I would prefer to be contacted with appointment information and test results as below:

_____.

I authorize Mid-Atlantic Family Medicine to disclose my medical information to:

Signature

Date

Witness