Meeting House Lane Medical Practice, PC

Acknowledgment of receipt of Privacy Notice

Today's Date: _____

I, _____ DOB: _____

(PLEASE PRINT PATIENT NAME\ GUARDIAN NAME) (DATE OF BIRTH)

Acknowledge that I have received a copy of:

Meeting House Lane Medical Practice Privacy Notice

Please check one of the following:

(_____) I authorize MHLMP to leave messages regarding appointments, test results, and/or medical treatment.

(_____) I authorize MHLMP to leave messages regarding appointments only.

(_____) I do NOT authorize MHLMP to leave messages regarding appointments, test results and\or medical treatment.

Disclaimer: MHLMP will still call in the event of a care coordination or billing question.

Please list anyone besides doctors that you allow us to release any medical information to. Under **NY State Law**, substance use, mental health and HIV information are considered confidential. Please put a check mark next to those we are able to discuss this information with.

Name:	Relationship:	Clinical Information	Substance Use	HIV	Mental Health
_____	_____				
_____	_____				
_____	_____				
_____	_____				

I do not wish to share any information with anyone

Patient/Guardian Signature: _____