LYNCH PRIMARY CARE
CONCIERGE MEDICINE

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that the providers of Lynch Primary Care has provided you access to a copy of its Privacy Notice which explains how your health information will be handled in various situations. By law, we are required to have you sign this form on your first date of service with us. If your first date of service with us was due to an emergency, we must try to provide you access to this notice and have you sign this form as soon as we can after the emergency.

Please specify by checking the appropriate answer below how we may BEST contact you or leave a message for you:

Home and/or answering machine	____ YES	____ NO
Work	____ YES	____ NO
Cell Phone	____ YES	____ NO
Personal E-mail	____ YES	____ NO

****Please note that if the above section is not completed, we will assume that we have your approval to contact you using any one of the above methods.**

THE PRACTICE HAS PROVIDED ME ACCESS TO ITS PRIVACY NOTICE. I UNDERSTAND I MAY REQUEST A COPY FOR MY PERSONAL USE.

THIS PRACTICE HAS CHOSEN TO PARTICIPATE IN THE CHESAPEAKE REGIONAL INFORMATION SYSTEM for our PATIENTS , INC. (CRISP), a statewide health information exchange. For more information on CRISP, please see our Notice of Privacy Practices.

_____ _____
Print Name **Date**

_____
Signature

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FINALLY: The Federal Government now restricts this OFFICE and the providers of Lynch Primary Care from discussing your health information and condition with other family members or persons - unless you specifically give your written permission.

By my signature below, I grant the office of Lynch Primary Care permission to discuss my protected medical information with the following individuals:

1. _____ 2. _____

SIGNATURE OF PATIENT: _____
(parent/guardian if a minor)