Houston Family & Geriatric Medicine

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Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient: _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient: _____

I authorize Dr. Suparna Chhibber, MD to release personal health information to the name (s) listed below:

Name(s): _____

Relationship to patient: _____

(Please check appropriate lines)

☐ Call my home/cell phone and if necessary leave a message on the answering machine/voice mail/with a family member for me to call you back to schedule an appointment or to return your call.

☐ Call my home/cell phone and if necessary leave a message on the answering machine/voice mail/with a family member giving the results.

Signature: _____ Date: _____

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