GREEN MOUNTAIN
PARTNERS FOR HEALTH

Name of Patient: ___________________________________ Patient Date of Birth: ______________________

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of 6/30/2016.

- We are required by law to maintain privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and have a copy of it available for you.
- We will not use or share your information other than as prescribed here unless you tell we can in writing. You may change your mind at any time. Let us know in writing if you change your mind.

_____________________________________ ______________________
Signature of Patient/Patient Representative Date

____
Relationship to Patient

Consent to Leave Messages

Green Mountain Partners for Health at times, we may need to contact you about test results, appointments, referrals or billing/insurance information. By filling out the information below, we will be better able to serve you. In an effort to protect your privacy and follow federal guidelines, we have developed on leaving medical care messages. Unless we have written permission to do so:

- We will NOT leave messages with anyone except the patient or legal guardian
- We will NOT leave messages on voice mail or answering machines
- We will NOT send emails

Please read below and carefully consider who, if anyone, you want to have access to your medical/account information.

I, ____ give my permission for Green Mountain Partners for Health to leave **phone** messages regarding my medical care/account information. I fully understand that this consent will remain valid until revoked in writing by me.

I, ____ give my permission for Green Mountain Partners for Health to send **email** messages regarding my medical care/account information. I fully understand that this consent will remain valid until revoked in writing by me.

Who else may we share your test results with on your behalf? Circle: Spouse/Partner/Mother/Father/Child
If yes, name: ____

Signature: ____ Date: _____________________________