Notice of Acknowledgement

This is to acknowledge that I have been provided with a copy of the **Privacy Policy Consent And Disclosure Of Protected Health Information.**

Patient Name: _____ Date: _____

I give my permission for Wolff Orthopedics and Sports Medicine to leave messages regarding appointments, diagnostic testing, account and/or insurance issues on :

My answering machine	yes	no
With family members	yes	no
My place of employment (Re: appointments only)	yes	no

Other (please list names & numbers) _____

_____

_____

_____

_____

_____

Patient Signature:_____ Date: _____

Effective April 14, 2003