Genesis Medical Associates
Bentz, Grob, Scheri & Woodburn Family Medicine
Acknowledgement of Receipt of Notice of Privacy Practices

I have reviewed a copy of this office's Notice of Privacy Practices. I am the patient, parent, legal guardian or have Power of Attorney for this patient and I am signing on their behalf. I authorize this office to use facsimile as a means of rapid communication with other physician's offices, pharmacies, laboratories and/or insurance companies for information that is pertinent to my care. I have read and understand the above statements

______________________________ ____________________
(Please print patient's full name) (Date of birth)

______________________________ ____________________
(Signature of Patient, Parent, Legal Guardian or Power of Attorney) (Date)

Reporting of test results and medical information

Messages may be left on my answering machine ___yes ___no

My test results and medical information may be shared with:

Name ____________________ Relationship ____________ Phone ____________

Name ____________________ Relationship ____________ Phone ____________

_____ Please **do not** release my information to anyone

Email appointment confirmations ______________________________

Name of pharmacy __________________ **location or phone #** __________________

Do you currently have an Advanced Directive/ Living Will ___yes ___no
If yes , we would like to have a copy for your file

Signature ______________________________ **Date** _______________