

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered a copy of the Notice of Privacy Practices and I have read (or had the opportunity to read if I so chose) and understand the notice.

Patient's name (please print)

Date

Signature

Relationship

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I request that all communications to me (by telephone, mail or otherwise) from Dr. Gardners office be handled in the following manner:

Written communications: Address to: _____

Oral communications: Call: _____

If we do not reach you by phone, we will leave a message at this number unless otherwise directed.

Patient's name (please print)

Date

Signature

Relationship