ROBERT D. MIXSON, M.D., P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have been provided with this practice's Privacy Policy to review. It is my understanding that the material in this policy is subject to change and that I may request a copy of the privacy policy at any time.

______________________________________ ______________________

Printed Name Date

____

Signature

DISCLOSURE OF PROTECTED HEALTH INFORMATION

By law, health information is confidential unless written authorization is given. Therefore, upon signing this form, I ____ am authorizing Robert D. Mixson M.D. to give medical information to:_________________________________.

Do we have your permission to contact you via phone to remind you about your scheduled appointment times or to provide you with other health information?

at home Yes No

____

or at work Yes No

____

or Cell # Yes No

____

Do / Do Not Leave messages on answering machine or voicemail.

Do / Do Not Mail appointment reminders or other correspondence to my home.
If not please provide alternate mailing address:

____

____

____

DO NOT disclose medical information to anyone other than myself. ___________

This remains in effect until I give written notification to discontinue.

______________________________________ ______________________

Signature Date