

Paul F. Wubbena, Jr. M.D., P.A.

Diplomate, American Board of Allergy and Immunology

Infants, Children and Adults

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement."

I, _____ have received a copy of this office's "Notice of Privacy Practices."

Please Print PATIENT'S Name

X

Patient/Guardian Signature

Relationship of Guardian to Patient

DATE

I authorize Dr. Paul F. Wubbena, Jr. and staff to discuss my personal health information, e.g. lab, x-ray reports, etc. with me and with those authorized by me (see below), by way of telephone, voicemail or answering machine using telephone numbers which I have provided.

Name(s) or individuals to which my PHI may be released or discussed with either in person, by telephone or by mail: (Note: Proper Identification will need to be provided when picking up records or discussing PHI on your behalf.)

Name

DOB

Name

DOB

X

Patient/Guardian Signature

Date

We attempted to obtain written acknowledgement of receipt of our "Notice of Privacy Practices", but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication Barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify) _____