

## Acknowledgement of Receipt of Notice of Privacy Practices

San Diego Sports Medicine and Family Health Center  
6699 Alvarado Road, Suite 2100, San Diego, CA 92120  
3880 Valley Centre Drive, Suite 201, San Diego, CA 92130  
Privacy Officer: Office Manager, Phone No. 619-229-3909

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at future office visits as any amendments are made.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate:

- Relationship:  parent or guardian of minor patient  
 guardian or conservator of an incompetent patient  
 beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_

### Methods of Communication Request

I request the use of the following methods of communication of information related to my personal health, treatment or payment for treatment. I acknowledge that I am responsible for updating this information as necessary. This request supercedes any prior request for methods of communication I may have made.

*Please select all that apply. Where you list more than one communication option, please indicate which you prefer.*

- Phone** You may contact me by telephone at \_\_\_\_\_

**May we leave messages concerning results of laboratory work, other diagnostic testing, or referrals to other providers on your answering machine or with someone in your household?**

- Yes  No

**Do you wish for our physicians and staff to have detailed conversations concerning your health care and condition with family members or designated others?**

- Yes **Name & Relationship** \_\_\_\_\_  
**Name & Relationship** \_\_\_\_\_  
 No

- Mail** (at the address provided on the registration paperwork)  
 **E-mail** You may contact me at the following e-mail address: \_\_\_\_\_  
 **Fax** You may contact me at the following fax number: \_\_\_\_\_

(Not all physicians and/or staff have access to e-mail for the purposes of communicating with patients. By providing your e-mail address or fax number, you are authorizing our physicians and/or staff to communicate with you by e-mail or fax, the content of which may include protected health information. You agree that we are not responsible for the interception of those messages by others.)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_