Patient Name____

Linzi L. Stewart D.O. PLLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.

Your name and signature on this sheet indicate that you have been given the opportunity to review and or request a copy of the Notice of Privacy Practices on the date indicated. If you have any questions regarding the information in the Notice of Privacy Practices, please do not hesitate to contact the Clinic manager.

*→ Patient Signature__________________________ Date__________________________

MEDICAL INFORMATION AUTHORIZATION

☐ ***I DO NOT** authorize the staff to leave a voicemail message on my phone which I provided to you in my demographic information.

☐ ***I DO** authorize the staff to leave a voicemail message on my phone which I provided to you in my demographic Information. *→

☐ ***I DO NOT** authorize the physician or staff to discuss my medical condition, treatment or test results with anyone other than myself.

☐ ***I DO** authorize the physician or staff to discuss my medical condition, treatment and test results with the following people:

____

Name | Phone | Relationship

____

Name | Phone | Relationship

____

*→ Signature of patient or legal representative | Date

____

Printed name of patient/legal representative | Relationship

* This will expire 1 yr from date signed.