Arlington Family Practice
22 Mill Street, Suite 101
Arlington, MA 02476

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY POLICY

I_____, acknowledge that Arlington Family Practice, PC has provided me with this notice of privacy practices and my rights regarding protected health information obtained by this practice. My questions have been answered and I understand this notice.

_____ _____
Signature of patient Date

Do we have permission to:

Leave a message on your home phone? _____Yes _____No

Leave a message at your place of employment or on a voicemail? _____Yes _____No

Obtain your medical records from anther facilities you may have been to? (ex. Hospitals, ER, etc.) _____Yes _____No

Discuss your condition with a member of your family? If yes whom? _____Yes _____No

_____
Relationship:_____

_____
Relationship:_____

This notice stays in effect unless otherwise communicated by patient in writing to Arlington Family Practice