

**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 another 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