Acknowledgement of Receipt of Privacy Notice

I have been given the opportunity to review the Boones Creek Medical "Notice of Privacy Practices" and understand that the notice describes how my information may be used and disclosed as permitted under Federal and Tennessee law. I have also been given the opportunity to take a copy for further review. I understand the contents of the notice, and I request the following restrictions concerning the use of my personal information:
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Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Patient or Guardian ______________________________ Date ____________________

Practice Representative ____________________________ Date ____________________

If for some reason the facility needs to relay my protected medical information, i.e. lab results and billing issues, you can either leave a message on my:

(X) To all that apply (if none apply, leave blank)

________**Home phone**
________**Cell phone**
________**Work phone**
________ **None of the above**

Or discuss the information with the following individual(s) (leave blank if you do not wish your medical information to be discussed with anyone)

Name:	Relationship:
1.________________________________	____________________________
2.________________________________	____________________________
3.________________________________	____________________________
4.________________________________	____________________________
5.________________________________	____________________________