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Colorado Springs, CO 80909
ph: 719-597-4200 fx: 719-597-4495
www.expresscareplus.net

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____(patient's name) acknowledge that I have received a copy of ExpressCare Plus' Notice of Patient Privacy Practices. This notice describes how ExpressCare Plus may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Signature of Patient/Legal Guardian **Date**

Printed Name **Relationship to Patient**

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I wish to be called at the following numbers regarding my care and follow-up. The best number(s) to reach me are:

Home # _____**Cell #**_____**Work #**_____

I do ____, I **do not** ____ give permission to leave detailed messages on my answering machine or voice mail.

I do ____, I **do not** ____ want relevant medical information shared with the persons listed below. The name(s) of the individual(s) with whom you may leave Protected Medical information are:

_____
(print name) **(relationship)** **(phone number)**

_____
(print name) **(relationship)** **(phone number)**

_____ _____
Patient Name (Please Print) **Patient Signature** **Date**