Corona Temecula Orthopaedic Associates
MEDICAL GROUP INC.

## Acknowledgment of Receipt of Notice of Privacy Practices

I have been offered a copy of the current Notice of Privacy Practices and understand a current Notice of Privacy Practices is available at my appointments and at www.CTOAMG.com.

Patient Name: _____ Date of Birth: _____

Signature: _____

Relationship to Patient if not "Self": _____ Date: _____

### Instructions for Communicating Protected Health Information (PHI)

Please indicate which of the following numbers and/or email address we should use to communicate with you regarding appointment reminders, lab results, etc. Only list the phone number, or numbers, you want us to call. Please specify if a message can be left on voicemail or with a designated person.

Cell _____ Message: *Yes / No*

Home _____ Message: *Yes / No*

Work _____ Message: *Yes / No*

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***Please note:*** *Emailing medically sensitive information can result in privacy breaches out of our control. For secure messaging, please join our patient portal at www.ctoamg.com.*

Email _____ *My initials indicate I understand the risks* _____

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My Protected Health Information may be communicated to:

_____

_____

_____

**Do not** communicate my Protected Health Information to:

_____

_____

_____

Initials: _____

**Office Use Only**

I attempted to obtain the patient's signature in acknowledgment of receipt of Notice of Privacy Practices but was unable to do so as documented below:

Date: _____ Employee Initials: _____

Reason: _____