Horizon Family Medical Group
HIPAA NOTICE OF PRIVACY PRACTICES

PLEASE RETURN TO RECEPTION TO FILE IN YOUR CHART

Yes No

☐ ☐ I have read the Privacy Notice

☐ ☐ I have been offered a copy of the Privacy Notice

☐ ☐ I have requested/received/declined a copy of the Privacy Notice
(circle one)

☐ ☐ I give permission to have information left on my answering machine

☐ ☐ I give permission for Horizon Family Medical Group to obtain prescription information electronically from any physician,pharmacy, or insurance company

☐ ☐ I give permission to leave information with my family member(s)

Name(s) of family member(s):

_____

_____

_____

_____

I acknowledge receipt of this notice:

Name (print): _____

Sign: _____ **Date:** _____

If you are signing as the patient's representative:

Name (print):_____

Describe your authority:_____

_____