Genesee Medical Group
7830 Clairemont Mesa Blvd. Suite 100, San Diego, CA 92111

Acknowledgement of Receipt of Notice of Privacy Practices
Health Insurance Portability & Accountability Act (HIPAA)

I hereby acknowledge that I have read a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed:_____ Date: _____

Print Name:_____ Telephone: _____

If not signed by patient, please indicate relationship:

☐ Parent or guardian of minor patient.

☐ Guardian or conservator of an incompetent patient.

☐ Beneficiary or personal representative of deceased patient.

Name of patient: _____

It is the policy of this practice to call your preferred phone number with an appointment reminder. Please inform the Office Manager if you wish to be removed from the call list.
_____ Initials

It is our policy not to routinely leave results and/or information on an answering machine or with a person other than the patient without expressed written consent. Please instruct us on your preferred method:

I, _____, do authorize the staff and/or physicians of Genesee Medical Group to leave messages including test results and general health information on

❑ My home answering machine **❑ My cell phone voice mail**
❑ My work voice mail **❑ My fax _____**
❑ By USPS to my home address
❑ By USPS to alternate address_____

I, _____, authorize the following person(s) to receive protected health information from the office of Genesee Medical Group, or any of the practicing physicians within:

Name/Address: _____

Relationship to patient: _____

Information authorized to receive: _____

Reason (may state "at request of individual"): _____

Name/Address: _____

Relationship to patient: _____

Information authorized to receive: _____

Reason (may state "at request of individual"): _____

Name/Address: _____

Relationship to patient: _____

Information authorized to receive: _____

Reason (may state "at request of individual"): _____

Patient Signature: _____

Date:_____