Patient Name (please print)_____DOB_____

NOTICE OF PRIVACY PRACTICES AND PHARMACY CONSENT RECEIPT OF ACKNLOWDEMENT

We are legally required to provide you with a copy of our NOTICE OF PRIVACY PRACTICES when you receive care at Oxford Internal Medicine. You can obtain a copy at our front desk.

Patient or Legal Representative check appropriate space and sign:

____ I have received a copy of the Notice of Privacy Practice

____ I do not want a copy or have received on past visit

X_____DATE_____
PATIENT OR LEGAL REPRESENTATIVE SIGNATURE

DISCLOSURE OF INFORMATION

I hereby authorize Oxford Internal Medicine to release the follow ing information:

____ Condition/Treatment/Plan of Care

____ Diagnostic/Laboratory Test Results

____ Current Medications

Authorized Person/Persons:

_____RELATIONSHIP_____

_____RELATIONSHIP_____

Permission to leave information on answering machine or voicemail? ____Y or ____N
Do you have a Durable Power of Attorney or Living Will on file with the Practice? ____Y or _____N
I give consent for information to be passed via e-mail. _____Y or _____N

I hereby give Oxford Internal Medicine permission to inquire/prescribe at the pharmacies listed below regarding any/all of my medications:

Local_____

Mail order_____