Martin D. Rudloff, MD, PC 851 E. Fifth St., Ste. 124 Washington, MO 63090

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND RELEASE OF MEDICAL INFORMATION

(You may refuse to sign this acknowledgement).

I, _____ have received a copy of this office's Notice of Privacy practices for my child/children _____

_____ .

Signature_____ Date_____

RELEASE OF MEDICAL INFORMATION AND TEST RESULTS

Our office would prefer to email or text normal or negative results that are not of a personal nature. Please indicate whether this is acceptable.

*Would you like your child's/children's/your test results e-mailed_____, texted_____, or called_____?

E-mail address_____ Preferred phone number_____

*May we leave your child's/children's/your medical information on your answering machine/voice mail? Yes_____ No_____

*May we leave a message with any other person(s) other than parent(s)/guardian(s) regarding medical information/test results? Yes_____ No_____

If yes, please list the name(s) and phone number(s) of the other person(s) with which we may leave a message.

Name_____ Relationship to child_____ Phone number_____

Name_____ Relationship to child_____ Phone number_____

Name_____ Relationship to child_____ Phone number_____

Signature_____ Date_____

_____

(FOR OFFICE USE ONLY. DO NOT WRITE BELOW THIS LINE).

Acknowledgement of the receipt of Privacy Practices could not be obtained because:
*_____individual refused to sign.
*_____a communication barrier prevented obtaining acknowledgement.
*_____an emergency situation prevented obtaining acknowledgement.
*_____Other (please specify) _____.