Acknowledgement of Receipt of Privacy Notice

I understand that in order to disclose my PHI (Protected Health Information), Dr. William L. Mulchin must have my consent. Therefore, I authorize Dr. William L. Mulchin and his agents to disclose my PHI as described on this form, to the recipients listed below:

Description of the information to be disclosed (check all that apply):

____All Procedures ____Radiology Reports ____Pathology Reports
____Lab results ____Office Notes ____Operative Reports

Name(s) of the person(s) authorized to obtain the above-mentioned information. Example: physicians other than your referring doctor, family members, other specified person(s)

Name______________________________________ Relationship______________

Name______________________________________ Relationship______________

Contact Information

I authorize Dr. William L. Mulchin MD and/or his agents to contact me at the following number(s)
concerning results, questions, confirmation of appointments, or any other information that is related to my care

( )Home__________May we leave results on your answering machine or voice mail? Yes No

( )Cell___________ May we leave results on your answering machine or voice mail? Yes No

( )Work__________May we leave results on your answering machine or voice mail? Yes No

I understand that when the information is disclosed pursuant to this authorization, it may be subject
to redisclosure by the recipient and may no longer be protected. Further, I understand that this con-
sent may be revoked at any time except to the extent that disclosure in good faith has already occurred in reliance to this consent. Otherwise, this shall remain in effect for 365 days.

OR

__**I do not authorize** Dr. William L. Mulchin or his agents to release my Protected Health Information to anyone other than myself. I fully understand that by doing so it may take longer to get my results.

Patient/Representative
Signature:__________________________Relationship:____________

Date:_________________________________Witness Signature:______________________