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I.	Acknowledgemen	t of Privacy Practice Notice	Date:	/ /	
room v	will be provided for yo	cal Associates, P.A. Privacy Pracuat your request. These rights are like a copy of this notice?	to inform you of you		
Patient	c's Name	Date of Birth	Signature of P	atient/Parent/	'Guardian
II.	Designation of Cer	tain Relatives, Close Friends	and Other Careg	<u>ivers</u>	
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member payment that is of the design my hear above.	er, close personal friend nt relating to my health directly relevant to the nate the following pers lth care for the purpose	ical Associates may disclose certal or other caregiver because such care. In that case, Woodbridge Medical serious involvement with my head ons listed below as persons involve of Woodbridge Medical Association of required to list anyone. I also	person is involved wanted and Associates whealth care or payment wed with my health cates' making the limit	ith my health ill disclose on relating to man are or paymented disclosure	care or ally information y health care. In relating to be described
Print N	ame:	Phone #	Relation	nship:	
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□Iw	ish to make no designa	tion at this time			
Signatu	re of Patient/Parent/Gu	Date			
Ш.	Designation of	eaving personal health infor	mation on you ans	wering mac	hine
	□ YES	□NO			
Signatu	re of Patient/Parent/Gu	ardian	Date		