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I. Acknowledgement of Privacy Practice Notice

Date: / /

A copy of Woodbridge Internal Medical Associates Privacy Practices Notice, located on the wall in our waiting room will be provided for you at your request. These rights are to inform you of your privacy and quality of care as a patient. **Would you like a copy of this notice? □ Yes □ No**

_____ _____ _____
Patient's Name Date of Birth Signature of Patient/Parent/Guardian

II. Designation of Certain Relatives, Close Friends and Other Caregivers

☐ INITIAL ☐ UPDATE

I agree that Woodbridge Internal Medical Associates may disclose certain portions of my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care. In that case, Woodbridge Internal Medical Associates will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of Woodbridge Internal Medical Associates making the limited disclosures described above. (I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.)

Print Name: _____ Phone # _____ Relationship: _____
Print Name: _____ Phone # _____ Relationship: _____
Print Name: _____ Phone # _____ Relationship: _____
Print Name: _____ Phone # _____ Relationship: _____

☐ I wish to make no designation at this time

III. Designation of leaving personal health information on your answering machine

☐ YES ☐ NO

_____ _____
Signature of Patient/Parent/Guardian Date