RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, ________________________, have reviewed a copy of The Peachtree City Physicians Group,
Print Patient's Name
PC's Notice of Privacy Practices.

_________________________DOB___________________ Today's Date ___________________
Signature of Guardian /Patient

PLEASE SIGN ONE OF THE FOLLOWING AUTHORIZATIONS:

I, ________________________**,** authorize Peachtree City Physicians Group to leave normal lab &
Signature of Guardian/Patient

radiology results and appointment reminders on my home/cell voicemail.

I, ________________________**, DO NOT** wish to have any medical information left on my
Signature of Guardian/Patient

home/cell voicemail.

NOTE: Peachtree City Physician Group PC will not leave medical information on home/cell voicemails that do not identify the patient by name.

PLEASE SIGN ONE OF THE FOLLOWING AUTHORIZATIONS:

I, ________________________, authorize Peachtree City Physicians Group PC to leave medical
Signature of Guardian/Patient

information regarding myself with __________________________ Relationship ____________**.**

I, ________________________, **DO NOT** authorize to release any medical information to anyone
Signature of Guardian/Patient

other than myself.

Would you like to be part of our patient portal? If so, please print your e-mail address here.

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