Sonoran Medical Centers, PLC
RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

1.Print

_____ _____ _____ _____
Printed **Patient**'s Name Patient Date of Birth Age Today's Date

CONSENT FOR CONTACT

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):
This consent for contact allows Sonoran Medical Centers to reach you regarding any test results (including lab work, radiology studies, biopsy results, and medications) or any other health information relating to your condition as designated below:
THIS CONSENT FOR CONTACT MAY BE CHANGED AT ANY TIME BY COMPLETING A NEW FORM.

2. Fill in

First Preference:
Phone # _____ Circle one: cell/work/home
□ OK to leave message with detailed information (check all that apply)
□ on answering machine
□ with designated person _____
□ Leave message with call-back number only (we will leave one message only)

Second Preference:
Phone # _____ Circle one: cell/work/home
□ OK to leave message with detailed information (check all that apply)
□ on answering machine
□ with designated person _____
□ Leave message with call-back number only (we will leave one message only)

Third Preference:
Phone # _____ Circle one: cell/work/home
□ OK to leave message with detailed information (check all that apply)
□ on answering machine
□ with designated person _____
□ Leave message with call-back number only (we will leave one message only)

X I will allow _____ to act on my behalf for all messages, appointments and results. (If patient is a minor, this must be completed.)

3.NEW!

□ Patient portal. My secure email address is _____

□ By mail only (this means you do not want us to call you by phone)
Address:_____

4. Sign

I acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____
Patient or legally authorized individual signature Today's Date

_____ _____
If not patient, printed Name of person signing Relationship (parent, legal guardian, personal representative, etc.)

Front ____ MA ____