

**ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE
AND DESIGNATION OF DISCLOSURE FORM**

I. Acknowledgement of Privacy Practice Notice

I have received a copy of the Sharon E. Selinger, M.D., Matthew L. Surgan, M.D. & Daniel T. Huberman M.D. Notice of Privacy Practices. I hereby consent to the use or disclosure of my protected health information by, or on behalf of, Sharon E. Selinger, M.D., Matthew L. Surgan, M.D. & Daniel T. Huberman M.D., for purposes of treatment, payment or healthcare operations. I understand that my protected health information may be used for such purposes without my written authorization.

Patient's Name

Date of Birth

Signature of Patient/Parent/Guardian

Date

II. I wish to be contacted in the following manner (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Home Telephone _____
<input type="checkbox"/> OK to leave message with detailed information
<input type="checkbox"/> Leave message with call back number only | <input type="checkbox"/> Written Communication
<input type="checkbox"/> OK to mail to home address
<input type="checkbox"/> OK to mail to work/office
<input type="checkbox"/> OK to fax to _____ |
| <input type="checkbox"/> Work Telephone _____
<input type="checkbox"/> OK to leave message with detailed information
<input type="checkbox"/> Leave message with call back number only | |
| <input type="checkbox"/> Cell Phone _____
<input type="checkbox"/> OK to leave message with detailed information
<input type="checkbox"/> Leave message with call back number only | <input type="checkbox"/> Other _____ |

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

I agree that Sharon E. Selinger, M.D., Matthew L. Surgan, M.D. & Daniel T. Huberman M.D. may disclose certain documents regarding my health information to a family member, close personal friend or other caregiver because such a person is involved with my health care.

I designate the person(s) listed below as individual(s) involved with my health care provided by Sharon E. Selinger, M.D., Matthew L. Surgan, M.D. or Daniel T. Huberman M.D. for the purpose of making the 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 by submitting a written request.

Print Name

Relationship

Date of Birth

Signature of Patient

Date