NORTH COAST PROFESSIONAL COMPANY, LLC DBA FIRELANDS PHYSICIAN GROUP

Privacy Notice Acknowledgement Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 I have specific rights to privacy of my personal health information.

I understand that North Coast Professional Company, LLC dba Firelands Physician Group may disclose my personal health information for treatment, payment, and the office's health care operations.

I have had the opportunity to receive a copy of the Notice of Privacy Practices and understand my rights and responsibilities as outlined in the notice.

I understand that North Coast Professional Company, LLC dba Firelands Physician Group may contact me regarding treatment and services and that the office will accommodate reasonable requests as to how I will receive such information as follows:

( ) Home Telephone: Ok to leave a message with a family member or on answering machine.

( ) Mobile Phone: Ok to leave a voicemail or communicate by text messaging.

( ) Written Communication: Ok to mail to my home address or email.

( ) Other: _____

( ) Restrictions: _____

( ) No Restrictions

Patient Name:_____ Signature: _____

Date:_____ Relationship to Patient:_____

Please list persons with whom we may discuss your medical condition and care along with their relationship:

_____

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