Masters Family Medical, PLLC

234 West Central Ave
Jamestown, TN 38556
(931) 879-8139

117 West Commercial Ave
Monterey,TN 38574
(931) 310-2900

Notice of Privacy Practices

Name: ___________________________________ Date of Birth: _____/_____/_____

Acknowledgment:

☐ I, the undersigned, acknowledge that I have received a copy of the Masters Family Medical Notice of Privacy Practices. I understand that this notice describes how my medical information may be used and disclosed, and how I can access my medical information.

☐ I understand that I have the right to review the Notice of Privacy Practices prior to signing this acknowledgment and that the clinic has answered all my questions regarding these practices.

By signing below, I confirm that I have read and understand the contents of the Notice of Privacy Practices.

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse ____

☐ Child(ren) ____

☐ Other ____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell number: ____________________________

If unable to reach me:

☐ you may leave a detailed message

☐ please leave a message asking me to return your call

The best time to reach me is (day) _________________ between (time) _______

Signed: ____ **Date**:_____/_____/_____

Witness: ____ **Date**:_____/_____/_____