DelVal Integrative Health Partners, LLC
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (please print) Date

_____
Patient or Authorized Representative (if applicable)

_____
Signature

AUTHORIZATION FOR VOICE MAIL USE

I authorize the staff of DelVal Integrative Health Partners, LLC, to leave appointment changes, appointment reminders or any other protected health information on an answering machine or voice mail at the following numbers:_____or_____(void if blank).

_____ _____
Signature of Patient or Authorized Representative (if applicable) Date

NOTE: It is the patient's responsibility to keep this information current.

AUTHORIZATION TO SEND MAIL

I authorize DelVal Integrative Health Partners, LLC to send me the statement of my account or any other correspondence or protected information in envelope(s) displaying full name and address of sender.

_____ _____
Signature of Patient or Authorized Representative (if applicable) Date

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices, but was unable to do as documented. _____Office Staff _____Date
Reason: