ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, _____, understand that as part of my health care, Thomas S. Eagan, M.D. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means to facilitate communication among the many healthcare professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for healthcare operations of Thomas S. Eagan, M.D., such as assessing quality of care and reviewing the competence of healthcare professionals.

I understand that as part of Thomas S Eagan, M.D.'s treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I understand and have been provided with a ***Notice of Privacy Practices*** that provides a more complete description of how Thomas S. Eagan, M.D., may use and disclose my protected healthcare information. I further understand that Thomas S. Eagan, M.D. reserves the right to change its ***Notice of Privacy Practices***. Should Thomas S. Eagan, M.D. change its ***Notice of Privacy Practices***, an amended copy will be posted in a prominent location in the practice site, or, upon my request, an amended copy will be sent to the address I have provided.

I agree that Thomas s. Eagan, M.D. may do the following unless I specifically give direction prohibiting such activity:

- Send visit reminders and test results to the address I have provided.
- Send routine correspondence, such as billing statements, to the address I have provided.
- Leave messages on an answering machine or voice mail associated with the telephone numbers I have provided to either confirm appointments or to request that I call the Practice on medical or billing matters.

Please list any contacts we may speak with regarding your care:

Contact: _____ **Relationship:** _____

Phone: _____ **Cell:** _____

Contact: _____ **Relationship:** _____

Phone: _____ **Cell:** _____

_____

Patient's Signature or Signature of Personal Representative

_____

Date

FOR OFFICE USE ONLY

[ ] Receipt received by _____ on _____

[ ] Patient refused to sign receipt. _____ (Signature or Practice Representative)