

**Acknowledgment of Receipt of Privacy Notice**

***ARIZONA ORTHOPEDIC & FRACTURE SURGEONS***

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

**X** \_\_\_\_\_  
Patient or legally authorized individual signature      Date

\_\_\_\_\_  
Printed Name if signed on behalf of the patient      Relationship (parent, legal guardian,  
personal representative, etc.)

The following instructions pertain to the above named patient:

- \_\_\_\_\_ OK to call home and leave message
- \_\_\_\_\_ Do not leave messages
- \_\_\_\_\_ Do not call home phone – call only this number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_.
- \_\_\_\_\_ Do not call work number
- \_\_\_\_\_ Call work number only
- \_\_\_\_\_ Permission to speak with family members listed below:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_ Do not speak to family members