CAPITAL HEALTH

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of Capital Health System's Joint Notice and Privacy Practices.

_____

Signature Date

Living Will:

Do you have a Living Will and Durable Power of Attorney? **YES** **NO**

If YES, please furnish us with a copy for your medical chart or allow us to make a copy to attach to your chart, Thank You.

If NO, would you like more information regarding this subject? **YES** **NO**

Contact Information:

When we need to contact you about test results, prescription refills, referrals, etc. can we leave a message on your:

Home: _____

Cell: _____

Capital Health Surgical Group has permission to speak to the following on my behalf:

_____

(Family or Friend)

I, _____ agree to the above.

Patient Name: _____ DOB: _____ DATE: _____