

Dianne C. Stone, M.D., P.C.

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

I, _____, have received a copy of Dianne C. Stone, MD, PC's Notice of Privacy Practices.

Signature of Patient

Date

CONTACT PERSONS WITH WHOM WE MAY DISCUSS YOUR CARE AND GIVE TEST RESULTS:

Name

Relationship

Phone Number

Name

Relationship

Phone Number

MAY WE LEAVE CONFIDENTIAL INFORMATION ON VOICE MAILS OR ANSWERING MACHINES LISTED BELOW:

Home Phone: _____

___ Yes ___ No

Work Voice Mail: _____

___ Yes ___ No

Cell Voice Mail: _____

___ Yes ___ No