Patient Release Form
&
Acknowledgement of Receipt of Notice of Private Practices

I. I understand that it is very important for New Horizons Internal Medicine LLC to be able to contact me regarding Labs/X-rays results or other information pertaining to my health information. I hereby give permission to New Horizons Internal medicine LLC Staff to leave information for me in the following ways:

(Please check all that applies)

_____1. Leave test results and other information on my home's answering service.
_____2. Leave test results and other information on my work's voice mail.
_____3. Leave test results and other information on my cell phone's voice mail.
_____4. Leave test results and other information with:
_____5. Leave test results and other information on my patient portal or email.
_____6. My spouse/ Partner (Name) _____
_____7. My parents (Name) _____
_____8. An adult child (Name)_____
_____9. Friend or co-worker (Name)_____
____10. Must contact me personally and directly (NO MESSAGES).

II. I have been presented with a copy of the Notice of Privacy Practice, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

I am acknowledging that I have received a copy of the Notice of Privacy Practice.

Signature:_____ Date:_____

Relationship (if not signed by patient): _____

I WISH TO PLACE THE FOLLOWING RESTRICTIONS ON DISCLOSURE OF MY HEALTH INFORMATION