MINOU W. COLIS, M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

(Please print patient name)

_____

(Please print name of legal guardian)

_____

(Signature)

_____

(Date)

REQUIRED

I do___do not ___ specifically consent to transferring my medical records via facsimile (fax) machine. This would include faxing any information to pharmacies for prescription refills, hospitals, other doctor's offices regarding your heath care, optical stores for eyeglasses and contact lens prescription refills or educational facilities.

For Office Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__Individual refused to sign

__Communication barriers prohibited obtaining the acknowledgement

__An emergency situation prevented us from obtaining acknowledgement

__ Other (Please Specify)