

**ACKNOWLEDGEMENT AND
REQUESTED RESTRICTIONS**

By signing below, you acknowledge that you have received *Affiliates of Family Medicine's Notice of Privacy Practices dated March 6, 2014* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

PRINTED NAMES & PHONE NUMBERS of people that confidential information can be released to:

Printed Name: _____ Phone #: _____

Printed Name: _____ Phone #: _____

Printed Name: _____ Phone #: _____

Printed Name: _____ Phone #: _____

Printed Name: _____ Phone #: _____

Printed Name: _____ Phone #: _____

Printed Name: _____ Phone #: _____

Printed:
Patient Name: _____

Date of Birth: _____

Signature

CIRCLE ONE:
Patient or Legal Representative

Printed Name

Date: _____

If Legal Representative, relationship to Patient: _____