



800 N Carriage Pkwy • Wichita, KS 67208
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I have received a copy of Wichita Family Medicine Specialists, LLC Notice of Privacy Practices with the effective date of April 14, 2003.

Printed Name

Signature of Patient or Patient Representative

Date

If Representative, Relationship to Patient

Do we have your permission to share Protected Healthcare Information with your:

Spouse _____

Adult Children _____

Adult Sibling _____

Friend/Personal Representative _____

Do we have your permission to leave messages on your answering machine:

(Please answer "yes" or "no")

a. Pertaining to appointments with a physician in our office or a specialist? _____

b. Pertaining to your laboratory or radiology test results? _____

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