



6200 E. Central • Wichita, KS 67208  
(316) 858-5800 • Fax (316) 858-5850

## 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? \_\_\_\_\_