Dr. Weberling & Associates
1701 Euclid Ave., Suite D
Bristol, VA 24201

137 Plaza Rd.
Wise, VA 24293

ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I, _____, have been provided access to a copy of the Notice of Privacy Practices from the office of Dr. Weberling & Associates either for myself or my child who is a patient.

_____ _____

Signature **Date**

_____

Signature of Witness

In order to protect the privacy and confidentiality of your protected health information Dr. Weberling & Associates and their staff members are requesting your permission to provide information to individuals other than yourself.

I agree / disagree that information directly related to my healthcare and billing can be released to family members, relatives, close personal friends or any other person identified below.

I agree / disagree to be contacted by telephone for appointment reminders, follow-up about treatment results, in an emergency at work and that you may leave messages on my answering machine.

Please identify individuals that you agree to allow Dr. Weberling & Associates and their staff members to communicate healthcare and billing information to:

Name_____ **DOB**_____

Name_____ **DOB**_____

Name_____ **DOB**_____

Name_____ **DOB**_____

_____

Signature of patient or legally authorized individual **Date**

_____

Relationship to patient, if signed by anyone other than the patient (Parent, legal guardian, personal representative, etc.)

The "Notice of Privacy Practices" for Dr. Weberling & Associates has been made available for my review.

Patients Initials_____