ACKNOWLEDGEMENT OF RECEIPT AND GENERAL CONSENT FOR HIPAA POLICES

I acknowledge that I have reviewed a copy of Dr. Kevin B. Wynne's Notice of Privacy Practices.

I further consent to the release of my health information for purposes of treatment, payment and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices.

I further give my permission to:

______ Leave a message on my cell phone or answering machine

_____ Leave a message with a family member or person answering my phone

Patient Name (print clearly) _____________________________________

Signature _________________________________ Date _____________

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of authority to sign this form:

Relationship To Patient_________________ Print Name _________________

Source of Authority ____