Acknowledgements for the Office of Roy A. Meals, MD, Inc.

Patient Contact Information Restriction Regarding your protected health information, please indicate the way(s) that our office may communicate with you. (please check all that apply):

Home Telephone

__OK to leave message with detailed information
__Leave message with call back number only

Work Telephone

__OK to leave message with detailed information
__Leave message with call back number only

Written Communication

__OK to mail to my home address
__OK to mail to my work/office address
__OK to fax to_____

You may release my protected health information to the following individual(s). I understand this authorization will be in effect until which time I revoke it.

Name _____ Relationship_____

_____ _____

✓ Signature_____ Please print your name_____ Date of birth_____

Receipt of Privacy Policy I received a copy of the Privacy Policy for the Office of Roy A. Meals, MD, Inc, that was available in the reception area. I understand that any amended Privacy Policy will be available at each appointment.

☐ I requested and received a copy of the Privacy Policy for my own records.
☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:_____

✓ Signature _____ Today's date_____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient

Patient name_____ Birth date_____0_____

Consent to Treat a Minor I (we) being the parent(s) or guardian of _____, a minor of age _____ , do hereby consent, authorize and request for Dr. Meals to administer such treatment deemed advisable, necessary or requested on the above-named minor.

✓ Signature of parent or guardian _____ Date: _____

Witness: _____

PLEASE TURN OVER