Madison Medical Affiliates, Inc.
Phone: 262-241-1919 Fax: 262-241-9046

Notice of Privacy Practices – Acknowledgement of Receipt

I, _____, acknowledge that I have received and reviewed the written
(Patient Name)
Notice of Privacy Practices from Madison Medical Affiliates, Inc.

Signed _____ **Date** _____
(Patient or legal representative or parent if patient under age 18)

Please indicate below how you would like Madison Medical Affiliates, Inc. to leave messages disclosing your protected health information:

___ Home answering machine # _____

___ Work phone # _____

___ Cell phone # _____

___ No messages should be left, speak to me directly.

The following are family members, legal representatives or a close friend I give permission to Madison Medical Affiliates, Inc. to disclose my protected health information with:

_____	_____	_____
(Individual's Name)	***(Relationship)***	***(Phone)***
_____	_____	_____
(Individual's Name)	***(Relationship)***	***(Phone)***

For Office Use Only:
Acknowledgement was unable to be obtained. Reason:
_____
_____

_____ _____
(Employee Signature) ***(Date)***