



JOHN S. ROGERSON, M.D., S.C.
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Privacy Notice Acknowledgement & Communication Authorization

Patient's Name: _____

My signature on this form acknowledges that I have reviewed a copy of John S. Rogerson M.D., S.C. Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be disclosed by John S. Rogerson M.D., S.C. and of my rights with respect to my health information.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

I hereby give permission to the office of John S. Rogerson M.D., S.C. to leave messages regarding medical matters on my answering machine at telephone number (_____) _____ - _____ if I am not available at the time of return call.

Yes No

I hereby give permission to the office of John S. Rogerson M.D., S.C. to convey medical information regarding my condition to my spouse, significant other, or close family member or friend as noted below if I am not available at the time of return call.

Name _____

Relationship _____

(_____) _____ - _____

Yes No

Patient's signature _____/_____/_____
Date

Signature of patient's representative if patient is unable to sign _____/_____/_____
Date

To Be Completed by Admitting Clinician if Form is Not Signed.

Was the patient provided information on "where to review" the Notice of Privacy Practices? Yes No

Briefly describe the efforts made to obtain the patient's acknowledgement of reviewing the Notice and explain why.

