

## New England Medical Specialists

### Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of N.E.M.S. Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under Federal and State Law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignments. Regulations pertaining to medical assignment of benefits apply.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE:**

If not signed by the patient, please indicate the relationship to the patient. (e.g., spouse)

Relationship: \_\_\_\_\_ Witnessed by: \_\_\_\_\_

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**INTERNAL USE ONLY:**

If the patient or patient's representative refuses to sign acknowledgment of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

Presented on (Date and Time): \_\_\_\_\_

By: (Name and Title): \_\_\_\_\_