Patient Privacy Acknowledgement

The Katherine M. Cyran M.D. Breast Center

1. I have received declined a copy of the Notice of Privacy Practices from

The Katherine M. Cyran M.D. Breast Center (Available to review on our website)

1. If we need to notify you regarding your examination at our facility please indicate how we may leave a brief message:
	1. Home Y N
	2. Work Y N
	3. Cell Y N
	4. Email Y N
2. Preferred method of Communication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. You may may NOT leave detailed information
4. May we provide the results of your examination via Email? Y N
5. Is there anyone else we may speak to regarding your medical information? Y N

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Printed Name Printed Name

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Relationship to You Relationship to You

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Phone Number Phone Number

1. Patient/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_
2. Printer Patient/Guardian Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_