



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND COMMUNICATION CHANNEL REQUEST**

I hereby acknowledge that I have received a copy of the Carmel Valley Pediatrics (CVP) Notice of Privacy Practices. I further acknowledge that a copy of the Privacy Practices is posted in the reception area. I understand that should the Privacy Practices be ammended, I will be given a copy of the amended Privacy Practices at my next visit.

I, \_\_\_\_\_ (print name) hereby request the use of the following channels for the communication of information related to my child's personal health, treatment, or payment for treatment. This request supercedes any prior request for confidential channel communications I may have made.

**Please check-mark all that apply. Where you list more than one communication option, please indicate by star which you prefer.**

**PHONE:**

\_\_\_\_\_ I want CVP to contact me by phone: (home) ( ) \_\_\_\_\_ - \_\_\_\_\_  
 \_\_\_\_\_ (cell) ( ) \_\_\_\_\_ - \_\_\_\_\_  
 \_\_\_\_\_ (work) ( ) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

\_\_\_\_\_ CVP may may not leave messages on my answering machine. (Circle applicable answer)

\_\_\_\_\_ CVP may may not leave messages with other family members. (Circle applicable answer)

**MAIL:**

\_\_\_\_\_ CVP may contact me by mail. My address is: \_\_\_\_\_  
 \_\_\_\_\_

**EMAIL:**

\_\_\_\_\_ CVP may contact me by email. My address is: \_\_\_\_\_

**FAX:**

\_\_\_\_\_ CVP may contact me by fax. My fax number is: ( ) \_\_\_\_\_ - \_\_\_\_\_

**PREFERRED PHARMACY: - This is the pharmacy we will call prescriptions into unless you notify us if different.**

\_\_\_\_\_ CVP may speak to my preferred pharmacy regarding any prescriptions provided CVP.  
 Pharmacy Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_ ext: \_\_\_\_\_

**OTHER:**

\_\_\_\_\_  
 Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Signature of Patient or Legal Guardian: \_\_\_\_\_  
 Print Name of Patient or Legal Guardian: \_\_\_\_\_