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NEUROLOGY CONSULTANTS CHARTERED

KIMBERLY A. COCHRAN, M.D.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

We are committed to securing the privacy of your health information. We are also required by law to give you a copy of our Notice of Privacy Practices. We would like for you to acknowledge in writing that you have received this.

I acknowledge that I have received a copy of Neurology Consultants, Chartered's Notice of Privacy Practices.

PATIENT SIGNATURE _________________________________ DATE _______________

PATIENT CONSENT TO LEAVE MESSAGES

Neurology Consultants has adopted a policy that requires our staff to obtain authorization from the patient in order to leave detailed messages. This policy is to insure that the patient's privacy is not violated. If we do not have a signed consent on file, the staff member may only leave their name and phone number with a request for a return call.

I give permission to the physicians and/or staff of Neurology Consultants to leave messages and/or speak with individuals designated below regarding my treatment, test results, account balance, or other relevant information … (CHECK ALL THAT APPLY)

1. ____________ On an answering machine

2. ____________ On voice mail at work

3. ____________ On my cell phone or cell phone voice mail: Cell # ________________

4. ____________ With ___________________________ relationship _______________

With ___________________________ relationship _______________

With ___________________________ relationship _______________

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5. ____________ I do not give permission for my health information to be discussed with anyone other than myself. Please contact me directly.

PATIENT SIGNATURE ________________________________

DATE __________________

This consent will be updated annually. **Consent expires _______**