Valley Care Clinics
The care you need, when you need it

**NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT**

I acknowledge that **Valley Care Clinics** provided me with a copy of its Notice of Privacy Practices as required under the Health Insurance Portability and Accountability Act of 1996

I authorize **Valley Care Clinics** and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them should this information change:

| | | |
|---|---|---|
| Home Telephone # | Yes | No |
| Answering Machine | Yes | No |
| Work Telephone # | Yes | No |
| Voice Mail | Yes | No |
| Cell Phone # | Yes | No |
| Fax to other Physician | Yes | No |

Please list names, relationship and numbers of family members or/and friends you wish us to release medical information pertaining to your healthcare.

| NAME | RELATIONSHIP | NUMBER |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

€ I do not wish any information pertaining to my healthcare to be released to family and/or friends.

Patient Signature: _____

Print Name: _____ Date: _____