



HIPPA: Acknowledgement of Receipt of Notice of Privacy Practices

Patient name (please print): _____

DOB: _____

I understand and hereby give my permission for health information (appointment scheduling, billing information, etc.) to be left in message form (voicemail, text, email and portal messaging) using the contact information provided to NP Nicole Oesterling.

In addition, the following individuals may also receive information regarding my care. Only the patient and individuals listed here will be able to receive information regarding appointments and general information.

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Signed: _____ **Date:** _____