FREDRIC R. MILLER, M.D., F.A.C.G.

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PRIVACY NOTIFICATION AND COMMUNICATION AGREEMENT

I acknowledge that I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

PATIENT SIGNATURE_____Date_____

TELEPHONE COMMUNICATION AUTHORIZATION

I authorize the office to contact me:

At home? ____Yes ____No

At work? ____Yes ____No

By cell phone? ____Yes ____No

May we leave a message on answering machine or voicemail? ____Yes ____No

If you have a Health Care Proxy, please indicate his/her name(s) and relationship:

_____

May we speak with other family members concerning your care? If so, please provide his/her name(s):

_____