Geetha M. Reddy, M.D., F.A.C.C.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I _____, have received the Notice of Privacy practices and have been provided the opportunity to review it.

Do you give Geetha M. Reddy M.D. and staff the permission to leave **detailed messages containing medical and /or financial information** on your answering machine?

At Home ( ) Yes ( ) No Phone#_____

At Work ( ) Yes ( ) No Phone#_____

On Cell ( ) Yes ( ) No Phone#_____

Do you give Geetha M. Reddy, M.D. and staff the permission to leave **appointment reminder/details** on your text message and email.

Cell/Data ( ) Yes ( ) No Phone#_____

Email address: _____

I give authorization to Geetha M. Reddy M.D. to discuss my medical information with the following people (you do not need to include treating physicians)

Name:	**Relationship:**	**Phone:**
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____

Patient Signature:_____Date:_____

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