ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices for **Primary Care Associates of NJ LLC.**

Print Patient Name:_____

Signature of Patient or Designee: _____*

Date:_____

*If person signing is not the patient, please print your name and relationship to patient:

Name: _____
_____

Relationship: _____

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For Office Use:
If no acknowledgment could be obtained, state the reasons why and the efforts taken to try to obtain the acknowledgment: _____

_____

_____

_____

_____

PERMISSION TO DISCLOSE MEDICAL INFORMATION TO ANOTHER

With regard to my/my child's medical condition and medical records, I give permission to the Staff of **Primary Care Associates of NJ, LLC.** to speak to the person(s) listed below. (You may indicate "no one".) Permission remains in effect until such time that it is specifically revoked in writing. You may, at any time, revoke any and all designees. Other doctors/medical entities need not be listed.

NAME: _____ **RELATIONSHIP:**_____

NAME: _____ **RELATIONSHIP:**_____

NAME: _____ **RELATIONSHIP:**_____

Patient Name Printed: _____

Patient/Guardian Signature: _____**Date:** _____

329 Main Road, Montville NJ 07045
973-334-9404 Fax 973-334-7615

PRIMARY CARE ASSOCIATES OF NJ, PA
Complete healthcare for the entire family