

**JOVE MEDICAL, INC.,
3111 45th Street, Suite 3
West Palm Beach, FL 33407
Phone: (561) 420-8820**

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of the *Notice of Privacy Practices*, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the *Notice*, and I request the following restriction(s) concerning the use of my personal medical information:

- Yes No We may leave test instructions, medication refill information, test and lab work results, or appointment information on your voice mail or answering machine.
- Yes No We may give test instructions, medication refill information, or appointment information to an immediate family member.
- Yes No We may discuss your medical condition, diagnosis, and/or test and lab work results with this immediate family member(s): _____
- Yes No We may fax your medical records to the following #: _____
- Yes No We may fax your medical records or insurance information to a hospital, imaging center, or doctor's office when necessary.
- Yes No We may send you information regarding your health care when necessary, to your home address.
To your email address: _____
- Yes No We may send you health news updates, quarterly newsletters, special announcements to your home address.
To your email address: _____

Further, I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____
**If not signed by patient, please indicate relationship to patient (e.g., spouse/parent)*

Relationship: _____ Witnessed: _____

Internal Use only:

If patient or patient's representative refuses to sign acknowledgment of receipt of notice please document the date the *Notice* was presented and sign below.

Presented on (date): _____ By (Name and title): _____