



Acknowledgement of Receipt of Privacy Practices

Greg T. Garrison, M.D.
Jill A. Johnston, M.D.
Kevin M. Ponciroli, M.D.
Ginny Minnigerode, C.P.N.P.

I, _____, have received a copy of this office's **Notice of Privacy Practices** that were placed in effect on **April 14, 2003**.

Please select Primary Care Physician

- Greg T. Garrison, MD
- Jill A. Johnston, MD
- Kevin M. Ponciroli, MD

Signature

Date

This notice is valid for all family members that receive medical services at this practice. Please list your children's names below.

Please select all that apply:

- I give this practice and its representatives consent to leave messages on my voicemail or answering machine.
- I do not give this practice and its representatives consent to leave messages with my voicemail or answering machine.
- I give this practice and its representatives consent to leave messages with the following person(s). _____ & _____.
- I do not give this practice and its representatives consent to leave messages with anyone other than parents or legal guardians.

Signature

Date