Oldendorf Medical Services, PLLC
Mark Oldendorf, MD Richard Balsam,
Michelle Gariepy RPA Cheryl Ernst, NP

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand and have been provided with a Notice of Privacy Practices that provides a description of how this medical practice may use and disclose my protected healthcare information. I further understand that the Practice reserves the right to change its Notice of Privacy Practices. Should the Practice change its Notice of Privacy Practices, an amended copy will be posted in a prominent location in the practice site.

Please review the questions below and answer yes or no:

Do you give us permission to **leave appointment messages**:

On home answering machine? Yes ☐ No ☐

On cell phone voicemail? Yes ☐ No ☐

On office voicemail? Yes ☐ No ☐

With another person? Yes ☐ No ☐

Sent via mail? Yes ☐ No ☐

Sent via e-mail? Yes ☐ No ☐

Do you give us permission to leave **medical information**:

On home answering machine? Yes ☐ No ☐

On cell phone voicemail? Yes ☐ No ☐

On office voicemail? Yes ☐ No ☐

With another person? Yes ☐ No ☐

Sent via mail? Yes ☐ No ☐

Sent via e-mail? Yes ☐ No ☐

The names of others who may receive information about my medical care:

Name:________________________ Phone #:________________ Relationship:______________

Name:________________________ Phone #:________________ Relationship:______________

Name:________________________ Phone #:________________ Relationship:______________

____ ____________________

Patient's Name (PRINT) **Date of Birth**

____ ____________________

Patient's Signature **Date**

Provider (please circle one): M. Oldendorf, MD R. Balsam, MD Michelle Gariepy, RPA Cheryl Ernst, NP

When a patient is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.

____ ____________________

Patient Representative Date

1365 Washington Avenue Suite 100
Albany, New York 12206
Office: (518) 435-1300 Fax: (518) 435-1397