**Viewmont Internal Medicine**
**1375 4th Street Drive NW**
**Hickory, NC 28601**

Acknowledgment of Receipt of Privacy Practices and Consent
Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices.
By signing this form, I hereby acknowledge that I have had the opportunity to read the Notice of Privacy Practices of Viewmont Internal Medicine and understand that in compliance with the Notice, this office is allowed to use or disclose my individually, identifiable health information for purposes of treatment, payment, and health care operations. I further understand that the Notice of Privacy Practices provides a more complete explanation of the use or disclosure of my individually identifiable health information.

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**Contact Authorization**

I hereby authorize Viewmont Internal Medicine to contact me and **leave messages** at my home, cell phone, work place, or with **listed family members when necessary to inform me of an appointment, appointment changes, billing concerns, or messages to contact the office. If inquiring person's name is not on this list, no information will be given.**

| **Member Name** | **Relationship to Patient** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**I have received a copy of Notice of Privacy Practices for Viewmont Internal Medicine**

_____ _____
**Patient Name (please print)** **Date of Birth**

_____ _____
**Signature (or patient's representative)** **Date of signature**