True Physician Care, LLC
10215 Fernwood Road, Suite 405
Bethesda, Maryland 20817

PRIVACY PRACTICE RECEIPT ACKNOWLEDGEMENT AND PERMISSIONS

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. Your signature below is only acknowledgement that you have received the Notice of Privacy Practices.

Signature _____ **Date** _____

Print Name _____

I give permission to True Physician Care, LLC to leave **voice, e-mail, and/or text messages** regarding my Protected Health Information and appointments at the following numbers and e-mail addresses:

Telephone

___Home _____

___Work _____

___Cell _____

E-Mail

___ E-Mail _____

Signature _____ **Date** _____

I give permission to True Physician Care, LLC **to discuss or release** my Protected Health Information with the following persons:

Name _____ Relationship_____

Name _____ Relationship_____

Name _____ Relationship_____

Signature _____ **Date** _____