



*North  
Scottsdale*  
FAMILY MEDICAL CENTER

**Brett Swenson, MD**  
21803 N. Scottsdale Road, Suite 125  
Scottsdale, Arizona 85255  
Ph 480-419-9924  
Fax 480-419-9908  
www.nsfamilymed.com

**ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE**

*Original to be maintained in patient's permanent record.*

I acknowledge that the office's Notice of Privacy Practices has been made available to me.

\_\_\_\_\_  
*Patient/ Legally Authorized Individual Signature*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
If signed on behalf of the Patient, please indicate Relationship to Patient (e.g. Parent, Legal Guardian, etc.)

**CONTACT INFORMATION**

I may be contacted in the following manner (circle all that apply):

- |  |        |       |      |    |
|--|--------|-------|------|----|
| - OK to leave message with detailed information: | Home   | Work  | Cell | No |
| - OK to leave call-back number only:             | Home   | Work  | Cell | No |
| - OK to send mail to:                            | Home   | Work  | Cell | No |
| - OK to fax to:                                  | Home   | Work  |      | No |
|  | Fax #: | _____ |      |    |

Those who may receive information regarding me:

- |              |                                   |
|--------------|-----------------------------------|
| _____ Spouse | Name of Spouse & birthdate: _____ |
| _____ Other  | Name and birthdate: _____         |
| _____ Other  | Name and birthdate: _____         |

\_\_\_\_\_  
*Patient Signature or  
Legally Authorized Individual Signature*

\_\_\_\_\_  
Date