South Denver Internal Medicine
A Concierge Medical Practice at Sky Ridge Medical Center
Charles H. Miranda, MD, FACP

PRIVACY NOTICE RECEIPT

You have the right to refuse to sign this acknowledgement

I _____, have been given the opportunity to read a copy of the practice's Notice of Privacy Practices. I also understand, that I have the right to request a copy of the Notice of Privacy Practices for my records.

_____ _____
Signature of Patient or Guardian if minor Date

_____
Please print name

I wish to be contacted in the following manner **(CHECK ALL THAT APPLY):**

_____ **Voicemail**

_____ **Text**

_____ **Personal Email** _____

_____ **Mail results to home address**

I authorize South Denver Internal Medicine to release my medical/billing information to the following individuals:

_____ _____
Name **Telephone**

_____ _____
Name **Telephone**