MICHAEL TAYMOR
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HIPAA-ACKNOWLEDGEMENT OF RECEIPT
Notice of Privacy Practices

Patient Name: ______________________________

Patient Birth Date: ____________________________

( ) I hereby acknowledge that I have reviewed the **HIPAA Notice of Privacy Practice** document.

( ) I agree to provide my child's immunization records to **CAIR** registry.
(CAIR: California Administration Immunization Registry)

( ) I agree to provide Dr. Taymor access to electronic submission for prescriptions which enables Dr. Taymor to view all medication that has been electronically submitted.

( ) I allow Dr. Taymor's office to send me automated calls and text messages.

_________________________________ __________
Signature of patient or patient's representative/parent Date

____
Printed name of patient or patient's representative/parent

____
Relationship to patient