Julie B. Stern, M.D.

Consent, Notice and Acknowledgement

I authorize the use and disclosure of my protected health information to include your office contacting me in the following manner: (check as many as applicable)

1. Home Telephone: _____
   _____ Leave detailed information
   _____ Leave message with office number only
2. Work Telephone: _____
   _____ Leave detailed information
   _____ Leave message with office number only
3. Cellular Telephone: _____
   _____ Leave detailed information
   _____ Leave message with office number only

I also authorize the following person/persons to whom my protected health information may be disclosed:

_____

_____

Acknowledgement:

I acknowledge that I have received the attached Notice of Privacy Practices.

_____ _____

Patient or Personal Representative Signature — Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____