ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I,_____, have reviewed/received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____ _____
(Signature) (Date)

I understand health information may be used or disclosed by mail, telephone, electronic means, and by fax. I authorize the use or disclosure of my health information for purposes of treatment, payment, or healthcare operations to other health care professionals involved in my care/treatment, insurance, third-party payers, pharmacies and the following relative (s) and/or others:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I wish to have the following restrictions placed on the use and disclosure of my health information:

I fully understand and accept the terms of the consent:

_____ _____
Name Date