Acknowledgement of Review of Notice of Privacy Practice

I am aware of this office's Notice of Privacy Practices. It explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Patient's Name

_____

Name of Parent or Personal Representative *(anyone you would not mind getting information, ie. appointment info, test results, surgery info.)*

_____

Relationship to Personal Representative's Authority *(spouse, child, relative, ect.)*

_____

Signature Patient or of Guardian (if patient under 18years of age) *Date*

_____

Witness