

Acknowledgement of Receipt of Privacy Notice

I acknowledge that the office's Notice of Privacy Practices has been made available to me.

Patient Name (Print)

Patient or Legally Authorized Individual Signature

Date

Printed Name and Relationship to patient if signed on behalf of the patient.

I give my permission for the following persons with whom to discuss my medical treatments and to receive test results:

Name(Print)

Relationship

Phone Number

Name(Print)

Relationship

Phone Number

Name(Print)

Relationship

Phone Number

Patient or Legally Authorized Individual Signature

Date