ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,		
law (or state law to the extent the state law provides greater access rights.) and/ or Refuse to sign this authorization.		
I have also been informed that the Notice of Privacy Practices is available in the waiting room for me to read.		
Signature of Patient or Personal Representative		
Description of Personal Representatives Authority Medical Record Release Release Information to:		
Name	Relationship to Patient	Contact Information/Fax Number
THIS INFORMATION REFERS TO INFORMATION DATED:		
Fr	omTo	
Patients Signature		DOB
Print name of patient		