

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that I received a copy of this medical practice's *Notice of Privacy Practices*. I further acknowledge my understanding and agreement to the standards set forth in the notice. I understand the practice will not use my Private Health Information for purposes other than those specifically described in the notice. Additionally, I understand that my Private Health Information may be used at the discretion of my physician or by his/her staff representative in order to facilitate my care with other physicians, laboratories/pathologists, or other healthcare professionals as necessary to render appropriate diagnosis and/or treatment.

Signed: _____ Date: _____

Signed by (please print): _____

If not signed by the patient, please indicate:

Relationship:

- .. parent or guardian of minor patient
- .. guardian or conservator of an incompetent patient

Name of Patient: _____