

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sign This Acknowledgement ***

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

 PLEASE PRINT NAME

X

 SIGNATURE

 DATE

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

 OFFICE PERSONNEL - PLEASE PRINT

X

 OFFICE PERSONNEL - SIGNATURE

 DATE

Patient Consent

Please sign this form below under the heading "Consent" to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosure of my information, which you deem are necessary in connection with my treatment, I understand that such disclosures may not be of the type listed above.

 PATIENT NAME - PLEASE PRINT

X

 PATIENT SIGNATURE

 DATE