

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature

DISCUSSION OF MEDICAL INFORMATION

List the family members or other person, if any, with whom we may discuss your medical care and your diagnosis (Your social security number must be known to this person in order for them to access confidential information)

Name _____ Relationship to You _____

Name _____ Relationship to You _____

Name _____ Relationship to You _____

Name _____ Relationship to You _____

Name _____ Relationship to You _____