PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

_____ _____

Print Patient's Name Date

I,_____, acknowledge that
(Signature of Patient or Parent or Legal Guardian)

I have received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I,_____, consent to the use and disclosure of my
(Signature of Patient or Parent or Legal Guardian)

personal health information by your office for Treatment, Billing/Payment and Healthcare Operations as outlined in the NOTICE OF PRIVACY PRACTICES.