Acknowledgement of Review of
Notice of Privacy Practices

I acknowledge I have received this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Disclosure of Medical Information:

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____

List family members, or other persons, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____