

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Foot and Ankle Clinic, P.C. reserves the right to modify the privacy practices outlined in this notice.

Signature

I have received a copy of the "Notice of Privacy Practices" for Foot and Ankle Clinic, P.C.

Patient Name (please print)

Signature of Patient

Signature of Patient Representative (if applicable)
(Required if patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

Date

You may disclose my medical/health information to:

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____