Notice of Privacy Practices - Acknowledgment

We Keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Please contact the front desk if you have any questions.

Our NOTICE OF PRIVACY PRACTICES describes in more detail how your health information may be used and disclosed and how you can access your information.

By my signature below I acknowledge and understand how my information may be used, and upon my request I may receive a copy of the NOTICE OF PRIVACY PRACTICES.

_____ _____

Patient of legally authorized individual signature date

_____ _____

Printed name if signed on behalf of the patient Relationship

This form will be retained in your medical record.