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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSURE FOR TREATMENT, PAYMENT AND OPERATIONS PURPOSES

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and health care operations of the office.

_____

Signature of patient or personal Representative

_____

Print name of patient or personal Rep. (including description of legal authority)

_____

Date