HIPAA ACKNOWLEDGEMENT

By signing this I am acknowledging that I have read and understand this office's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of Privacy Practices. I understand that, by signing this acknowledgement and consent form that I am giving my consent for this office's use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

<<patient_full_name>>
Signature

If this acknowledgement is signed by a personal representative on behalf of the patient please complete the following

Guardian or Personal Representative's Name:

Signature