

**PATIENT ACKNOWLEDGEMENT OF
THE NOTICE OF PRIVACY PRACTICES
AND CONSENT FOR USE AND DISCLOSURE OF
PERSONAL HEALTH INFORMATION**

Print Patient's Name Date

I, _____, acknowledge that I
(Signature of Patient or Parent or Legal Guardian)
have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that
this
office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I, _____, consent to the use and disclosure of
(Signature of Patient or Parent or Legal Guardian)
my personal health information by your office for Treatment, Billing/Payment and
Healthcare
Operations as outlined in the NOTICE OF PRIVACY PRACTICES.