PATIENT ACKNOWLEDGMENT

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

For Office Use Only

__ Patient refused to sign

__ The following circumstances prohibited the patient from signing the acknowledgment.

_____

_____

_____

__ An emergency situation prevented the patient from signing the acknowledgment.

_____
Office Personnel (signature)

_____
Office Personnel (print name)

Date_____

_____
***Patient Signature**

_____
***Patient Name (please print)**

***Date**_____

PATIENT CONSENT

I consent to your disclosure of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

_____
***Patient Signature**

_____
***Patient Name (print name)**

***Date**_____