ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOURE 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 this 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 healthcare operations of this office.

_____

Print Name of Patient or Legal Guardian

_____

Signature of Patient or Legal Guardian

_____

Date