**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 Health care Operations as outlined in the NOTICE OF PRIVACY PRACTICES.