Acknowledgement of Privacy Practices

I, _____, have received a copy of the Notice of Privacy Practices from The Doctor's Office @ 83 S. Main.

Furthermore, I authorize the release of information about my care to the following individuals:

Name	Relationship	Phone Number

This authorization for release can be revoked by the patient at any time by notifying the staff of The Doctor's Office @ 83 S. Main.

_____

Patient Signature

_____

Date