

INTERNAL MEDICINE DIAGNOSTICS

197 HOSPITAL DR., SUITE B

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Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

Print Name of Patient: _____

Signature of Patient: _____

Date: _____

Patient's Date of Birth: _____

Patient's ID/Chart Number: _____

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: _____

Describe Personal Representative Relationship (parent, guardian, etc): _____

Signature of Personal Representative: _____

Date: _____

For Practice Use Only:

Signature of Practice Employee

Date