ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a copy of *Notice of Privacy Practices, Revision 0, EVELINE ASSAD, M.D., P.C.,* detailing how my information may be used and disclosed as permitted under federal and state law.

I wish to have the following restrictions to the use or disclosure of my health information (Eveline Assad, M.D., P.C. is not required to agree with these restrictions):

_____

I permit a copy of this authorization to be used to request payment of medical insurance benefits.

Patient Name: _____ Signature: _____ Date: _____

If not signed by patient, indicate relationship (e.g., spouse)

Relationship: _____ Witnessed by: _____

_____

OFFICE USE ONLY

If patient refuses to sign, the employee giving copy of the notice will complete the following:

( ) Patient refuses to sign this Acknowledgement.

Date: _____ Time: _____ Employee Name: _____