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Receipt of Notice of Privacy Practices Form

I, _____, hereby acknowledge receipt of the
(name of authorized parent or guardian)
Physician's Notice of Privacy Practices. The notice of privacy Practices provides
detailed information about how the practice may use and disclose my confidential
information.

I understand that the physician has reserved a right to change his or her privacy
practices that are described in the Notice. I also understand that a copy of any
Revised Notice will be provided to me or made available.

I understand that this consent is valid until revoked by me. I understand that I may
revoke this consent is valid until revoked by me. I understand that I may revoke
this consent at any time by giving written notice of my desire to do so, to the
physician. I also understand that I will not be able to revoke this consent in cases
where the physician has already relied on it to use or disclose my health
information. Written revocation of consent must be sent to the physician's office.

Name of patient/patients:

1. _____
2. _____
3. _____
4. _____

Relationship to patient:

Signature:

Date:
