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PRIVACY OFFICIAL: *DONNA LESKO, R.N.*

NOTICE OF PRIVACY PRACTICES RECEIPT

I ACKNOWLEDGE THAT I WAS INFORMED OF THE NOTICE OF PRIVACY PRACTICES OF THE MEDICAL PRACTICE NAMED AT THE TOP OF THIS PAGE AND A COPY IS AVAILABLE UPON REQUEST.

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: _____

I AM GIVING AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO THE FOLLOWING PERSONS:

_____ _____
Name Relationship

_____ _____
Name Relationship