

## Acknowledgement of Review of Notice of Privacy Practices

I have received this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

\_\_\_\_\_  
Signature of Patient or Guardian of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

### **NOTE:**

Please list additional family members we may disclose biopsy and lab results to, if you are unavailable.

1. \_\_\_\_\_ 2. \_\_\_\_\_

This authorization will remain in effect unless you specify written changes.

\_\_\_\_\_  
Signature of Patient or Guardian of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Patient