Arthritis & Osteoporosis Center, P.C.

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ACKNOWLEDGEMENT RECEIPT OF PRIVACY PRACTICES

(to be filed in patients medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed:_____ Date:_____

Print Name:_____

Relationship (if not signed by patient):_____

I wish to place the following restrictions on disclosure of my health information:

Internal Use Only
If patient/patients representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time):_____ Signed:_____