RECEIPT OF PRIVACY PRACTICES

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of, or had the opportunity to read, the NOTICE OF PRIVACY PRACTICES (located in the waiting room).

I have read them or declined the opportunity to read them and understand the NOTICE OF PRIVACY PRACTICES.

I understand this form will be placed in my patient chart and maintained for a period of six years.

DATE:

PATIENTS NAME (PLEASE PRINT)

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SIGNATURE

PLEASE LIST BELOW THE NAME AND RELATIONSHIP OF PEOPLE TO WHOM YOU AUTHORIZE RELEASE OF PHI.

THIS FORM WILL BE MAINTAINED IN THE PATIENT'S CHART FOR A PERIOD OF SIX YEARS.