PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

FROM THE OFFICE OF:

SHARON B. DIAMOND, MD, FACOG

DATE:____

Patient Name (Please Print):____

ACKNOWLEGEMENT AND CONSENT

By signing below, I acknowledge that I have been provided with a copy of the Notice of Privacy and have therefore been advised of how health information about me may be used and disclosed by the office of Dr. Sharon B. Diamond, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS related information, alcohol and substance abuse treatment information, mental health information and genetic information. Finally by signing below I consent to the use and disclosure of my health information to treat me and arrange for my medical care, and to seek and receive payment for services given to me as for the business operations of this practice, its physician, and its staff.

Patient Signature____

(Or) Name of Personal Representative (Please Print):________________________________

Signature of Personal Representative____