ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

______________________________ ________________

Patient Name (please print) Date

____

Parent, Guardian or Patient's legal representative

____

Signature

Atlantic Foot & Ankle Associates maintains a confidentiality policy with all patients' medical information. Please list the names of those that you give this office permission to speak with concerning your medical condition.

I ____hereby give permission for this office to give information regarding my medical condition with the following:

____Initial ___________ Date___________

____Initial ___________ Date___________

____Initial ___________ Date___________

____Initial ___________ Date___________

____ Date ___________________________

Signature of Patient