ACKNOWLEDGEMENT OF RECEIPT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our Practice and whom you may contact at our office to ask questions about our privacy practices.

By signing this form, you agree that you received and have had the opportunity to read our Notice of Privacy Practices.

I have received a copy of the Notice of Privacy Practices for Stony Point Family Medicine.

_____ _____

Patient's Name (Print) Social Security Number

_____ _____

Patient's Signature Date
(Or patient's representative)

With your permission we may disclose your location and general health condition to a family member, personal representative or any other person responsible for your care. If you wish, please, identify the person (s) we can share your information with below; if not, please, leave it blank.

_____ _____

Person's Name Relationship to Patient

_____ _____

Person's Name Relationship to Patient

_____

Patient's Signature