MARION LUQUE PLLC

LOUIS SCHLICKMAN MD PLLC

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you the opportunity to view and/or receive our Notice of Privacy Practices, (which states how we may use and/or disclose your health information) as well a copy of the Office Policies and Procedures.

My signature below acknowledges that I have had an opportunity to view and/or receive a copy of the Provider's Notice of Privacy Practice and agree to the Office Policies and Procedures.

_____

Please print your name here

_____

Signature: Date:

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below name(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Phone Number: _____ I agree to accept brief messages at the number provided.

Email: _____ I accept all responsibility for transmitting my PHI electronically to this email address. I realize that giving this email address is voluntary.

Fax Number: _____ I accept any potential risk associated with the use of this fax number in transmitting my PHI.

Employee Signature _____ Date _____