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NOTICE OF PRIVACY PRACTICES—ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Jan Shaw, Office Manager.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Name of Patient ______________________ Date of Birth ____________ Today's Date ____________

Signature: parent, legal guardian, personal representative ______________________ Relationship ____________

Printed name if signed on behalf of the patient ______________________ Signature of Patient if age 14 or older ____________

(Notation, if any, by staff)

This form will be retained in your medical record.

Last Update: 4/11/03

I give my permission to the following people to seek medical care or medical advice on my behalf for my child.

Please print:

Name	Relationship	Phone
		( )
		( )
		( )
		( )

FORM #LWPRINT021610