

# ACKNOWLEDGEMENT 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 ( or had the opportunity to read if so chose ) ;Or may view it and print it at [www.DrAssalita.com](http://www.DrAssalita.com) and understood the notice.

PLEASE COMPLETE THE FOLLOWING ( those on web , print out this and other forms and bring to your office appointment )

PRINTED NAME :

\_\_\_\_\_

Printed name and relationship of Parent or authorized Representative :




\_\_\_\_\_

Signature: \_\_\_\_\_

DATE: \_\_\_\_\_

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Note: please indicate who you authorize hear,  see,  , talk  Or otherwise communicate about you and release your records information to at this time ; and their status to you. You do not need to indicate anyone. However, please note, if for example, you have a spouse or companion, and they want to inquire on your behalf about anything ( including your bills etc ), if you do not list them, we cannot communicate with them until we would then get your permission. You may want to consider also listing a spouse , if you are here with your child. Or adult children, if you are elderly / live alone.


NAME: \_\_\_\_\_ STATUS: \_\_\_\_\_

NAME: \_\_\_\_\_ STATUS: \_\_\_\_\_

NAME: \_\_\_\_\_ STATUS: \_\_\_\_\_

NAME: \_\_\_\_\_ STATUS: \_\_\_\_\_



NOTE :  We can communicate about medical issues directly to other physicians , but it is also nice to list them here, if you want copies of y our consultation or other notes to go to them . Please add addition information as needed.  
Thanks.