ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, hereby acknowledge the offer to receive a copy of the Notice of Privacy Practices which describes how Borimir J. Darakchiev, MD, may use and share my protected health information.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.) and/ or
- Refuse to sign this authorization.

I have also been informed that the Notice of Privacy Practices is available in the waiting room for me to read.

_____ Date_____

Signature of Patient or Personal Representative

_____

Description of Personal Representatives Authority

Medical Record Release

Release Information to:

Name	Relationship to Patient	Contact Information/Fax Number

THIS INFORMATION REFERS TO INFORMATION DATED:

From_____To_____

Patients Signature_____DOB_____

Print name of patient _____