

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a written copy Elkhart Podiatry Clinic Privacy Practices.

Signature of Patient _____

_____ Date

Printed Name of Patient _____

Patient Date of Birth _____

Patient Social Security Number _____

Account Number (Office Staff Only) _____

Signature of Representative of Patient _____

_____ Date

Printed Name of Representative of Patient _____

If there is anyone else you would like to make available to your medical records (family, doctors, attorney, etc.), please list below:

<u>Full Name</u>	<u>Phone Number</u>	<u>Relationship to Patient</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

EPC Representative _____

_____ Date