Acknowledgement and Requested Restrictions

By signing below, you acknowledge that you have received this Notice of Privacy Practices prior to any service being provided to your by the practice and you consent to the use and disclosure of you medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information.

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Patient Name: ____

(Please Print Name)

Patient Date of Birth: ____

Signatures:

Patient/Legal Representative: __________________________________ Date: __________________________________

If Legal Representative, relationship to Patient: ____

Witness (Optional): ____ Date:__________________________________

Preferred Pharmacy: ____

Address and Phone Number: ____________________________________

Please include your email address: _________________________________