PHYSICAL MEDICINE ASSOCIATES, INC

Notice of Privacy for Protected Health Information

Acknowledgement of Receipt of Notice of Privacy Practices

I have received Physical Medicine Associates, Inc. Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the Notice.

Patient Name: ____

Patient Signature: ____ Date: __________

Patient was given Privacy Notice and refuses to sign acknowledgement.

____ ______________

Employee Signature Date

Please list any person(s) who you authorize Physical Medicine Associates, Inc to discuss your protected health information, including billing information and balances owed. If at any time you do not want Physical Medicine to discuss your protected health information with any listed person, you must notify Physical Medicine Associates in writing.

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Name Relationship

____

Name Relationship

____

Patient Signature Date