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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES AND CONSENT TO
USE AND DISCLOSURE FOR TREATMENT,
PAYMENT AND OPERATIONS PURPOSES**

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office.

Signature of Patient or Personal Representative

Print Name of Patient or Personal rep. (including description of legal authority)

Date