Acknowledge of Receipt of

John Shinin's Medical Practice

Notice of Patient Privacy

By my signature below, I hereby acknowledge receipt of this Notice of Privacy Practice and I acknowledge that the Practice will use and disclose my health. information for purposes of treating me, obtaining payment for services rendered to me, and conducting health care operations.

I have been advised of my rights to obtain access to and control my Protected Health Information.

_____ _____

Signature of the Patient or of Personal Representative or Parent/Guardian

Date

_____ _____

Authorized additional Member to obtain Access of my Health Information

Relationship