JASSER CENTER
FOR COMPREHENSIVE CARE

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Patient Name: _____ Date of Birth: _____
(Please print)

I acknowledge that I have been provided the Notice of Privacy Practices ("Notice"):

- The Notice tells me how the Practice will use my health information for the purposes of my treatment, payment for my treatment and the Practices heal care operations.
- The notice explains in more detail how the Practice may use and share my health information for other than treatment, payment and healthcare operations.
- The Practice will also use and share my health information as required/permitted by law.

Signature of Patient or Guardian _____ Date _____

Printed Name of Guardian _____ Description of Authority _____

Address: _____

Phone Number _____