ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides information about how the practice may use and disclose my confidential information. **I am only acknowledging receipt of the policy.**

Please specify your relationship to the patient: ________________________________

________________________________ ________________________

Signature of patient or representative Date

INFORMATION AUTHORIZATION

For the Foot and Ankle Center of Illinois, Ltd. to disclose private health information about you to parties not covered in our Notice of Privacy Practices, you will need to complete this section.

❑ Yes, you may provide information to the parties listed below:

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❑ No, I do not wish the Foot and Ankle Center of Illinois, Ltd. to discuss my information with any party other than myself.

________________________________ ________________________

Signature of patient or representative Date