Privacy Notice Acknowledgment

Michael Bublik, MD

Patient Name: _____ Date _____

By my signature below, I acknowledge that I have read and/or received a copy of this office's HIPPA (Health Insurance Portability and Accountability Act) Privacy Notice, and that a copy is available to me at any time.

I have listed the names(s), relationships(s) and phone numbers of persons I authorize to receive my protected health information:

Name_____Relationship:_____Phone:_____

Name_____Relationship:_____Phone:_____

Name_____Relationship:_____Phone:_____

_____ _____

Signature of Patient (or Authorized Representative) Date

_____ _____

Name of Authorization Representative Relationship to patient