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RECEIPT FOR NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

____ ____________________________
Patient Name (please print) Date

____
Parent -or- Authorized Representative (if applicable)

____
Signature

****

Please only complete the section below if you wish your health information to be shared with someone other than your primary care doctor.

AUTHORIZATION FOR RELEASE OF INFORMATION:

I hereby authorize *Dr. Jennifer Sartori, DPM, PLLC* and/or staff to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization and may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient name: ____ Date of birth: ____________________

Persons / organizations to receive the information if requested: ____

____

I understand that this authorization will remain in effect until rescinded in writing by the undersigned.

____ ________________________
Signature of patient or patient representative Date

Printed name of patient representative & relationship to patient: ____

** You may refuse to sign this authorization **