ARTHRITIS CONSULTANTS, PC

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE AND HEALTH INFORMATION NOTICE

Patient Name: ______________________________ Date of Birth: ________________________________

I acknowledge that I have been provided the Arthritis Consultants, PC ("Practice") Notice of Privacy Practices:

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

I acknowledge that I have been provided the Arthritis Consultants, PC ("Practice") Notice of Health Information Practices ("Notice"):

- It tells me how Practice will electronically share health information with a Health Information Organization (HIO).
- The notice explains in more detail how I may Opt-out of sharing my health information with the HIO.

______________________________	______________________________
Signature of Patient or Personal Representative	Date
______________________________	______________________________
Name of Patient or Personal Representative	Address
______________________________	______________________________
Description of Personal Representative's Authority	Telephone