Robert F. Hoofnagle, Jr., M.D., P.A.
Acknowledgement of Notice of Privacy Practices

I understand a copy of the Notice of Privacy Practices for this office can be made available at the time of my visit. I understand the Notice of Privacy Practices contains a complete description of the uses and disclosures of my health information. I understand this office has the right to change its Notice of Privacy Practices at any time and I may contact this office at any time and obtain a current copy.

Please select one of the following:

_____ I wish to receive a copy of the Notice of Privacy Practices.

_____ I do NOT wish to receive a copy of the Notice of Privacy Practices. (I understand there is a copy in the office & may request a copy at any time.)

Accessibility of Your Healthcare Information

Please select one of the following:

_____You may speak with family/friends with regards to the treatment or payment of my medical care**.**

_____You may NOT speak with family/friends with regards to the treatment or payment of my medical care, unless I give you specific written permission at a later time.

Please sign to acknowledge that the above indicates your requests concerning your medical information.

_____ _____

Patient Printed Name *Patient Date of Birth*

_____ _____

Patient/Guarantor Signature *Date*

_____

Relationship to patient (For minors/POA)

OFFICE USE ONLY: I attempted to obtain the patient's signature in acknowledgement, but the patient refused.
_____ Employee Initials