CRUMAY PARNES ASSOCIATES, INC.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

By signing below, I acknowledge that I have been provided the Practice Notice of Privacy Practices, which contains a detailed description of the uses and disclosures of my health information and I have been given an opportunity to read the Notice.

____
Print name of Patient

________________________________ _________________
Signature of Patient Date
(or patient's personal representative)

Personal representative information (if applicable):

____
Name of personal representative

____
Relationship to patient (or other authority)

Medical information may be released to:

____
Name Relation

____
Name Relation

____
OFFICE USE ONLY

If unable to obtain the patient's signature in acknowledgment of receipt of the HIPAA Notice of Privacy Practices, document the reason below (emergency etc).

Patient Name:____ Date:________________
Reason:____

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