Convenient Care Family Medicine
Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this Convenient Care Family Medicine's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Name of Patient or Personal Representative

_____ _____
Signature of Patient or Personal Representative Description of Personal Representative's Authority
(Example: Parent, Guardian)

_____
Date

I **decline** to review the Notice of Privacy Practices at this time. I understand that there is always a copy available for my review and that I may request to review the notice at any time during office hours or that there is a copy posted at www.yourhometowndoctor.com .

_____
Signature of Patient or Personal Representative

_____
Date