# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below, I authorize being contacted by Natural Medicine Institute:

By Telephone___

Telephone Number(s)_____ _____

By Voice mail___

By Email____ Email Address_____

_____ _____

Patient Name (please print) Date

_____

Name of Patient's Guardian or Legal Representative

_____

Signature of Patient, Parent, Guardian, or Patient's Legal Representative

List below the names and relationship of people to whom you authorize Natural Medicine Institute to release PHI. All Medical Records of Natural Medicine Institute patients, regardless of whether they are created at, or received by Natural Medicine Institute, and patient lists and billing information, are the property of Natural Medicine Institute. The information contained within the Medical Record are accessible to the patient and thus made available to the patient and/or his or her legal representative upon appropriate request and authorization by the patient or his or her legal representative. We will not release records to any third party except as required by law or statute.

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