NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting [name or title of Privacy Officer].

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient or legally authorized individual signature Date Time

_____ _____

Printed name if signed on behalf of the patient Relationship
(Parent, legal guardian, personal representative)

Authorization for Medical Photography

I, the undersigned, hereby authorize Dr. Carol Hathaway to take photographs of me as may be necessary or desirable for the proper and efficient medical care of my case.

I further understand that such photographs are to be the sole property of Dr. Carol Hathaway and may not be exhibited or shown by said doctor to medical, non-medical groups, and or individuals in the interest of medical science without special authorization from me.

_____ _____

Signature Date

Notation if any by staff
This form will be retained in your medical record.
Last Update_____