



VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received the Notice of Privacy Practices prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

Patient Name: _____

(Please Print Name)

Patient DOB: _____

SIGNATURES:

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to Patient: _____

Witness (optional) : Date: _____