

Patient: _____
Last Name First Name M. I. SSN

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In general, any information that is about your health, the health care you receive or payment for that care is considered confidential and protected by practice. We may need to use your protected health information to carry out treatment, payment, health care operations and/or other purposes. Our Notice of Privacy Practices provides a more complete description of permitted uses and disclosures.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Drs. Murray, Murray & Groves.

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative: _____
Relationship to the patient _____

