ACKNOWLEDGEMENT
RECEIPT OF NOTICE OF PRIVACY PRACTICES

Office of Donald Gedarovich, MD, PC
Effective Date: April 14, 2003

By signing this form I acknowledge the receipt of Notice of Privacy Practices which provides me with detailed information about how the Practice of Donald Gedarovich, MD, PC may use and disclose my protected health information for the purposes of treatment, payment and health care operations.

I also understand that if the Practice amends its Notice of Privacy Practices, I will be informed of the change and may obtain a copy of the revised Notice by: contacting the office at (508) 660-8874, for a copy.

I have the right to request, in writing, how the Practice uses and discloses my protected health information for the purposes of treatment, payment, or health care operations and that the Practice is not required by law to grant my request. However, if the Practice does decide to grant my request, the Practice must adhere to the approved restrictions unless it is an emergency situation or it is in direct conflict with state or federal laws and regulations.

Patient's Signature Date

Patient Name (print) Date of Birth

Signature of Legal Representative
(if patient unable to sign)

Print Name Date

Relationship of Representative to the Patient