Damian Garcia, M.D.
Family Medicine

ACKNOWLEDGEMENT

To Receipt of *Notice of Privacy Practices*

I understand that as part of my healthcare, Damian Garcia, M.D. Family Medicine (Provider) originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers, and in other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals, and as required or permitted by law without my consent.

The Provider's *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of, or access to, the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this acknowledgment. I understand that the Provider reserves the right to change the *Notice of Privacy Practices.* Prior to implementation of a revised *Notice of Privacy Practices*, the revised *Notice* may be mailed to me if I provide my mailing address below.

I have been provided and have reviewed the Provider's *Notice of Privacy Practices* dated **September 2014**.

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Signature of Patient or Legal Representative

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Print Name of Patient or Legal Representative

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Print Name of Patient, if different

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Date

I request that changes to the *Notice of Privacy Practices* be sent to me at this address:

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Please list below anyone you would allow to have access to your medical information, make phone calls on your behalf, or obtain results to any testing. They will be required to have your consent, and prove their identity prior to obtaining receipt of any information

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