Acknowledgment Of Receipt
Of
Notice Of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices from Richard C. Galperin, D.P.M., P.A. and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (Please print) Date

_____
Parent or Authorized Representative (If applicable)

_____
Signature

Please list below the following people whom we may release information to in regard to your medical condition

1._____
2._____

If your child is a minor please fill out the following:

I hereby authorize Richard C. Galperin D.P.M. to care for the below mentioned minor and to administer therapy as deemed medically necessary or advisable in the diagnosis and treatment of this patient.

_____
Patient's Name (Please print)

_____ _____
Signature (Parent or Guardian) Date

_____
Relationship

_____ _____
Witness Date