



CENTER FOR PRIMARY CARE

FAMILY MEDICINE

ACKNOWLEDGMENT OF RECEIVING PRIVACY POLICY AND AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

By signing below, I acknowledge that I have received a copy of the Privacy Policy of the Center for Primary Care (CPC), and that I authorize CPC to use and disclose my protected health information for the purposes of treatment, payment, and healthcare operations, as described in the Privacy Policy.

Signature of Patient or Authorized Representative

Today's Date

Print Name of Patient or Authorized Representative

Print Relationship to Patient, if applicable