PATIENT ACKNOWLEDGEMENT AND RECEIPT OF PRIVACY PRACTICES

PRACTICE NAME: TREASURE COAST OBSTETRICS AND GYNECOLOGY
1000 37th Place, Suite 105
Vero Beach, FL 32960

My signature below acknowledges that I, ________________________, have received and read a copy of Treasure Coast Obstetrics and Gynecology's privacy notice.

Signature of Patient: ________________________________

Printed Name of Patient: ____________________________

Date: ____________________

OPTIONAL:

I ______________________give my permission to ____________________ to receive all medical information regarding my care while I am patient at this practice.

Signature of Patient: ____________________________________