

ACKNOWLEDGEMENT FORM: PRIVACY NOTICE

Raynon A. Andrews, M.D., P.C.

I have been presented with a copy of **Raynon A. Andrews M. D., P.C.'s**, Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state laws. I understand the contents of the notice. If I have any requests restricting the use of my personal medical information, I will provide such request in writing to **Raynon A. Andrews, M.D., P.C.**

Name: _____

Signature: _____

Date: _____

Relationship: _____

If not signed by patient

Witnessed By: _____

IF THE PATIENT REFUSES TO SIGN, NOTE YOUR ATTEMPT TO OBTAIN A SIGNATURE BELOW.

Patient has refused to sign this Acknowledgement Form.

Reason for refusal: _____

Date: _____

Time: _____

Employee Name: _____

Witness: _____