ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices 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

Authorization for Co-Participation of Health Care

I, ______________________ ______________ ______________________
Print patient 's name Date of Birth Patients Phone Number

Authorize Dr. Carter and staff to discuss my health care and other protected information as indicated to the designated person(s) below.

Co-Participant Name	Contact Number	Relationship	Date of Birth
Co-Participant Name	Contact Number	Relationship	Date of Birth

Information Authorized:

- ( ) ALL Health Care Information
- ( ) Diagnosis
- ( ) Treatment
- ( ) Lab Work
- ( ) Appointment Information
- ( ) Insurance/Reimbursement
- ( ) Other: Please Specify ______________________

I understand that I must present suitable photo identification when requesting this release of confidential information.

______________________________ ______________
Patient Signature Date

______________________________ ______________
Parent/Legal Guardian Date