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/Dr. Price 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