

**Acknowledgement of Receipt of the Notice of Privacy Practice**

**Your name and signature on this document indicate that you have been given the opportunity to review and request a copy of the Notice of Privacy Practices for The Medical Office of Antonio A. Flores, M.D. P.A. on the date indicated. Additionally, you consent to the use and disclosure of your medical information as set forth in the Notice of Privacy Practice except as expressly stated below. If you have any questions regarding our medical office’s Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the Patient Privacy Officer as indicated on your Notice.**

**May we release your health information to family member(s) or any other individual or care giver(s)?**

**( ) YES ( ) NO**

**If yes**, please list name and relationship below:

Name: Relationship:

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I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

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Patient Name Patient’s Date of Birth

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Patient Signature Date

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Personal Representative Signature (if applicable) Relationship to patient