

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I acknowledge that I have been given the opportunity to read and receive a copy of Charles J. Breen, MD, PSC's Notice of Privacy Practices.

Date: _____

Signature (Patient or Authorized Representative): _____

Printed (Patient or Authorized Representative): _____

For Office Use Only:

If you are unsuccessful in obtaining a signature from the patient or authorized representative, please explain the reason and circumstances on the lines below:

Signature of Staff Member: _____ Date: _____