

Park Cities Allergy & Asthma
Vinita Schroeder, M.D. P.A.

Patient's Acknowledgement of Receipt

By signing this form, I acknowledge that Park Cities Allergy & Asthma has provided me with a copy of PF-1000 Notice of Privacy Practices and that I have read and signed PF-2000 Consent to Use and Disclosure of Protected Health Information.

Name of Patient (Please Print)

Signature of Patient

Date

Signature of Patient Representative (if patient is a minor)

Relationship of Patient Representative to Patient

Park Cities Allergy & Asthma staff should complete if Acknowledgement of Receipt form is not signed.

Does Patient have a copy of the Privacy Notice?

() Yes () No

Please explain why the patient was unable to sign an acknowledgement from.

