ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

Jeffrey A. Marks, DPM

I acknowledge that I was provided a copy of the Notice of Privacy Practices as it pertains to the office of Jeffrey A. Marks, DPM.

_____ _____

Patient Name (Please Print) Date

_____

Authorized Representative (If applicable)

_____

Signature of Patient

I authorize my personal health information may be disclosed to the following individuals.
You have the right to add or remove any names on this list at any time.

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship