Primary Care Medical Associates, Ltd.

Acknowledgement of Privacy Policy

Patient Name: _____

Date of Birth: _____

Telephone Number for Lab or Test Results: _____

I acknowledge that I have been offered a copy of the Primary Care Medical Associates Privacy Policy. This policy includes, but is not limited to, information about Primary Care Medical Associates' use and disclosure of your health information.

We reserve the right to change our privacy practices in accordance with the law, and the terms in our policy may change also. A summary of our Privacy Policy is posted in the waiting room of our office, and a copy of this policy is given to each new patient at their first appointment. Additional copies of this Privacy Policy are available upon request.

I understand that it is my responsibility to read the policy I have been offered, and if I have any questions or need clarification I may speak to any member of Primary Care Medical Associates, Ltd.

_____ _____ (or)
Date Signature of Patient

_____ _____
Date Signature of person authorized by law