Alan B. Birnkrant, M.D.

For Office Use Only

Patient Name: _____

Medical Record #:
_____

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

I acknowledge that the office of Bruce G. Bonn, M.D., Sara L. Imershein, M.D., and Alan B. Birnkrant, M.D. has provided me with a copy of their Notice of Privacy Practices. This document explains how my health information is handled in various situations. By law, the doctors are required to have me sign this form on my first date of service.

I have reviewed the Notice of Privacy Practices. I have discussed any concerns or questions about this notice and the privacy of my health information with Bruce G. Bonn, M.D., Sara L. Imershein, M.D., Alan B. Birnkrant, M.D. and/or the Office Manager.

PLEASE CHECK ONE:

☐ I have retained a copy of the Notice of Privacy Practices for my personal use.

☐ I do NOT want a copy of the Notice of Privacy Practices and have returned it to the staff of Bruce G. Bonn, M.D., Sara L. Imershein, M.D., and Alan B. Birnkrant, M.D. I may obtain a copy of this notice at any time.

_____ _____

Patient Signature Date

_____

Patient Printed Name