

NAME OF PATIENT \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

HOME # \_\_\_\_\_ CELL # \_\_\_\_\_ FAMILY M.D. \_\_\_\_\_

BUSINESS OR EMERGENCY PHONE \_\_\_\_\_ REFERRED BY \_\_\_\_\_

BILLING INFORMATION  
(IF DIFFERENT THAN ABOVE)

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ANDREW J. PARKER, M.D.  
ACKKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_ acknowledge that I have received a copy of Andrew J. Parker, M.D.'s Notice of Privacy Practices. This notice describes how Andrew J. Parker, M.D. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

\_\_\_\_\_  
(Signature of Patient or Personal Representative)

\_\_\_\_\_  
(Relationship to Patient)