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By signing below, I acknowledge that I have been made aware of the NOTICE OF PRIVACY PRACTICES (HIPPA) of the office of Eldersburg Arthritis, regarding the protection of my personal health information.

Patient Name: _____

Date of Birth: _____

Please list any persons (i.e. spouse, parent, etc.) you give permission to obtain your personal health information.

_____

_____

_____

_____

Signature of Patient: _____
(Or parent, if a minor)

Date: _____

A Copy of our Privacy Practice (HIPPA) is available to you upon request.