Internal Medicine of Blue Ash
9330 Kenwood Road
Cincinnati, Ohio 45242

Acknowledgment of Receipt

Of

Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

PLEASE LIST ANY FAMILY MEMBERS/FRIENDS ETC. WHOM WE MAY RELEASE INFORMATION TO REGARDING YOUR HEALTH.

____

____

____

____
Patient Name (please print)

____
Parent or Authorized Representative (if applicable)

____________________________________ ______________
Signature Date