

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

POCATELLO PODIATRY

Ambulatory Foot and Ankle Clinic
1555 EAST CLARK
POCATELLO, IDAHO 83201

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

Patient Name (please print)

Date

Parent of Authorized Representative (if applicable)

Signature

AKCNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

POCATELLO PODIATRY

Ambulatory Foot and Ankle Clinic
1555 EAST CLARK
POCATELLO, IDAHO 83201

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

Patient Name (please print)

Date

Parent of Authorized Representative (if applicable)

Signature