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PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I acknowledge that I was provided with a copy of the Juvenal Martinez, M.D., P.A. notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. Provided that Juvenal E. Martinez, M.D., P.A. continues in its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my health information for the purposes and the activities permitted under the federal privacy law, which are described in the Notice of Privacy Practices.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (305) 598-6696 or by requesting one at your office.

______________________________ ____________________
Patient Name Date

______________________________ ____________________
Signature of Patient or Personal Representative Personal Representative's Relationship to Patient

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FOR PHYSICIAN OFFICE USE ONLY:

You must complete this section of the form if not signed and dated by the patient or patient's representative.

Patient Name: ____________________ Date of Birth: ________________

Social Security Number; ________________ Phone Number: ________________

Address: ____

The date that you requested the signature and date: ____________________

The reason that the signature and date were not obtained:

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