LONGEVITY
ACUPUNCTURE

ACKNOWLEDGEMENT OF REVIEW OF PRIVACY NOTICE

I acknowledge that I received a copy of the Practice's Privacy (HIPAA) notice that has an effective date of April 14, 2003.

_____ _____

Patient Name (Print) Signature

Date signed: _____

If you wish your information to be disclosed/discussed with, i.e. spouse, parent, relative, caretaker, secretary/assistant. Such information may include but not be limited to scheduling of appointments, discussing your condition/treatment with the doctor, account information, health plan benefits, etc. Please list name(s) below.

1. _____
2. _____
3. _____