For Treatment: We will use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, nurses, technicians and other office personnel who are involved in providing you medical treatment.
(This office requires a signed authorization for release of medical information to other physicians or medical facilities, patient, patient's family / representative, insurance company other than the patient's insurance on date of service).

EXHIBIT P4:
Receipt of Notice of Privacy Practices
Written Acknowledgement Form

FRED M. NOVICE, M.D.

PRACTICE NAME:

I am a patient of FRED M. NOVICE, M.D.; I hereby acknowledge receipt of Fred M. Novice, M.D.'s Notice of Privacy Practices.

I give my permission to the staff of Fred M. Novice, M.D. to leave a message for me on my email, voice mail or answering machine or send U.S. mail regarding my healthcare, follow up care and accounting.

I give permission to the staff of Fred M. Novice, M.D. to share information regarding my healthcare and accounting to the following individuals:

Please select, at least, one option below:

☐ No one else (staff will speak with patient only, will only leave message to call the office of Fred M. Novice M.D.)

☐ Spouse: Print Name: _____ Telephone: _____

☐ Child: Print Name: _____ Telephone: _____

☐ Other: Print Name: _____ Telephone: _____

Patient Name (PLEASE PRINT): _____

****Patient Signature:** _____ Date: ____/_____/_____

Patients under the age of 18/ Legal Guardian

I am a parent or legal guardian of : (Print **PATIENT'S** name) _____

I hereby acknowledge receipt of Fred M. Novice, M.D.'s Notice of Privacy Practices with respect to the patient.

Name (PLEASE PRINT): _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

****Parent / Legal Guardian Signature:** _____ Date: ___/____/___