CHABOT FAMILY ASSOCIATES, INC.
19845 LAKE CHABOT ROAD, #205 CASTRO VALLEY, CA, 94546
2324 SANTA RITA RD, SUITE 8 PLEASANTON , CA, 94566
PH: 510-582-6424 FAX: 510-582-6462

I _____, Date of birth _____ certify that I have been made aware of Chabot Family Associates' **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Chabot Family Associates' health care operations. The Notice also describes my rights and Chabot Family Associates' duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of Chabot Family Associates' web site at www.karewellmd.com. I may request a printed copy during my visit**.**

Chabot Family Associates reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by asking for one at the time of my next appointment, or by accessing Chabot Family Associates' web site listed above to view the most current version.

I _____ Request the following restriction on the use or disclosure of my health information. I understand that the Physician reserves the right reject the request of non-disclosure and I will be informed of the same.

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SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE OR PARENT

_____
PLEASE PRINT NAME OF PERSON SIGNING THE FORM

_____
DATE

_____
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY / PARANT OR GUARDIAN's RELATIONSHIP

CHABOT FAMILY ASSOCIATES, INC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES