

PHI CLINIC

HIPAA ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of PHI Clinic's Notice of Privacy Practices, which explains how my protected health information may be used and disclosed and how I may access this information.

I understand that PHI Clinic may use and disclose my protected health information for purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

I understand that I may request a copy of this Notice at any time.

Patient Name: _____

Signature: _____

Date: _____

PHI Clinic
Ernesto Padron, MD
Medical Director | Board Certified Family Medicine
Miami, Florida