

CHABOT FAMILY ASSOCIATES, INC. 20130 LAKE CHABOT RD, #202 CASTRO VALLEY, CA, 94546 PH: 510-582-6424 FAX: 510-582-6462

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, Date of b	oirth certify that I have been made
aware of Chabot Family Associates' Notice of	of Privacy Practices and that I have a right to receive
a copy upon request. This Notice describes the	of Chabot Family Associates' Notice of Privacy Practices and that I have a right to receive upon request. This Notice describes the type of uses and disclosures of my protected health ation that might occur during my treatment, to facilitate the payment of my bills or in the nance of Chabot Family Associates' health care operations. The Notice also describes my and Chabot Family Associates' duties with respect to my protected health information. I tand that copies of the Notice of Privacy Practices are available in the registration areas of t Family Associates' web site at www.karewellmd.com . I may request a printed copy during t. It Family Associates reserves the right to change the privacy practices that are described in tice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by asking for the time of my next appointment, or by accessing Chabot Family Associates' web site listed to view the most current version. Request the following restriction on the use or disclosure health information. I understand that the Physician reserves the right reject the request of lisclosure and I will be informed of the same.
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SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE OR PAREN	s Notice describes the type of uses and disclosures of my protected health cur during my treatment, to facilitate the payment of my bills or in the family Associates' health care operations. The Notice also describes my Associates' duties with respect to my protected health information. I fethe Notice of Privacy Practices are available in the registration areas of s' web site at www.karewellmd.com . I may request a printed copy during as reserves the right to change the privacy practices that are described in actices. I may obtain a revised Notice of Privacy Practices by asking for at appointment, or by accessing Chabot Family Associates' web site listed urrent version. Request the following restriction on the use or disclosure. I understand that the Physician reserves the right reject the request of the informed of the same. Representative or parent I REPRESENTATIVE OR PARENT WING THE FORM ENTATIVES AUTHORITY / PARANT OR GUARDIAN'S RELATIONSHIP
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	CHABOT FAMILY ASSOCIATES. INC.