**ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have been offered from Redpoint Medical, PSC a copy of the “Notice of Privacy Practices”.

I understand that Redpoint Medical, PSC may need to use and disclose information about my health or medical issues for the purpose of arranging, conducting, or referring of my treatments, for obtaining payment for the services rendered to me and for the operation of the practice. I consent to the use of my information for the purposes of treatment, payment and healthcare operations.

Redpoint Medical, PSC reserves the right to modify the privacy practices outlined in the notice.

Patient Signature: Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_