SUMMIT
ORTHOTICS &
PROSTHETICS

Acknowledgement of Receipt of Notice of Privacy Practices

Date:_________________

I, (Patient's Name)____ Date of Birth:____________________

Acknowledge and agree that I have received or was offered a copy of Summit Orthotic and Prosthetic's Notice of Privacy Practices.

I authorize Summit Orthotics and Prosthetics to discuss my personal health information (PHI) with:

____
Name and Relationship to patient

I authorize Summit Orthotics and Prosthetics to leave voice messages regarding my care at the number I have provided.

- ☐ Yes Phone Number:________________________
- ☐ No

____
Patient Signature Date

____
Patient Representative Date