Family Practice Associates
a professional corporation

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Receipt of Privacy (HIPAA) Practices
Written acknowledgement form

I acknowledge that the privacy policy for Family Practice Associates, Inc. has been made available to me in accordance with HIPAA regulations.

_____
Print name

_____
Signature

_____
Date

Family Practice Associates, Inc. has my permission to share my medical and health information, including test results with:

_____ NO ONE

Name	Relationship	Initial
Name	Relationship	Initial
Name	Relationship	Initial
Name	Relationship	Initial
Name	Relationship	Initial

This permission can be changed at any time by me. All I need do is come in and fill out and sign a new form.