

# Drum Hill Primary Care

I have received a copy of the Notice of Privacy practices. The Notice describes how my personal health information by be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time.

\_\_\_\_\_  
Date

\_\_\_\_\_  
\*Signature

\_\_\_\_\_  
Print or Type Name

\*As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

\_\_\_\_\_  
Date

\_\_\_\_\_  
\*Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Print or Type Name