Acknowledgement of Receipt of Privacy Practices

Dr. Scott Brunengraber, Smithtown Wellness, and its agents, are dedicated to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all uses and potential disclosures of your health information by our practice and outlines your rights with regards to your health information. Please sign the form below to acknowledge your receipt of our *Notice of Privacy Practices*.

I acknowledge receipt of the Notice of Privacy Practices for Dr. Scott E. Brunengraber/Smithtown Wellness

Name_____

Signature_____ Date_____

Witness_____ Date_____

The following persons below are permitted to discuss my care at this office with the staff of Smithtown Wellness.

Name_____

Address _____

Phone Number _____

Permission granted for ◯ 90 days or ◯ until I revoke.

Name_____

Address _____

Phone Number _____

Permission granted for ◯ 90 days or ◯ until I revoke.

Patient Signature _____ Date _____