Notice of Privacy Practices

Privacy Practices Acknowledgment
FASV, P.C.

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Patient Name: _____Birth date:_____
PRINT NAME

You may discuss or release my medical information to:

Name:	**Relationship:**	**Gender:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient or Parent Signature: _____

Date: _____