Please read Private Policy statement then print and sign form.

Jonathan P. Shapiro, MD PLLC
115 East 61st Street, 3rd Fl.
New York, NY 10021

ACKNOWLEDGEMENT OF RECEIPT AND GENERAL CONSENT

I acknowledge that I received a copy of the Notice of Privacy Practices. Basically, the Notice states that the practice will safeguard my private health information as required by law. This private health information will be used only for the purposes of my treatment, obtaining payment for services rendered, and ongoing operations of the office. Any other use will require specific authorization by me.

I consent to the release of my health information for purposes of treatment, payment, and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices.

Patients Name _____

Signature _____ Date _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____

Print Name _____

Source of Authority _____