JAMES J. DeLORENZO, D.P.M

Physician of Podiatric Medicine and Surgery

21 Old Main Street, Suite 107
Fishkill, New York 12524
Tel 845.897.FEET *Fax* 845.897.3335
www.delorenzopodiatry.com

Notice of Privacy Practices Patient Acknowledgement

I understand that under the Health Insurance Portability Accountability Act of 1998, I have certain rights to privacy in regards to my protected health information. I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read, if I so chose) and understood the Notice.

The Practice reserves the right to change the terms of its Notice of Privacy Practice. I understand the Practice will provide current Notice of Privacy Practice on request.

____

Patient Name

____

Patient or Authorized Representative Signature:

____

Date:

**** Please note: As a convenience, the Notice of Privacy Practice is located in our patient waiting room. If you would like a copy of this please notify our receptionist and she will be happy to provide you with one. Thank you.***