ANDREW B. CHERTOFF, M.D., P.C.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I (or on behalf of)_______________________________________ do hereby
(please print patient name)

acknowledge that I have been offered a copy of the Notice of Privacy Practices of Andrew B. Chertoff, M.D., P.C.

____ ________________

Signature (Patient/Parent/Guardian) **Please Circle** Date

_____ Patient is incapacitated and unable to sign the Notice of Privacy Practices form.

_____ Patient refuses to sign the Notice of Privacy Practices form.

DISCLOSURE OF INFORMATION

I hereby grant Andrew B. Chertoff, M.D., P.C. permission to disclose information to the following duly authorized person(s).

1. __________________________________ __________________
(please print name) (relationship)

2. __________________________________ __________________
(please print name) (relationship)

3 __________________________________ __________________
(please print name) (relationship)

4. __________________________________ __________________
(please print name) (relationship)

5. __________________________________ __________________
(please print name) (relationship)

6. __________________________________ __________________
(please print name) (relationship)