Kimberly A. Pummill, M.D., P.C.
8384 Holly Road, Suite 1
Grand Blanc MI 48439
810-606-7888

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, ____, have been given the opportunity to review the Notice of Privacy Practices as provided by Kimberly A. Pummill, MD, PC. I have also been given the opportunity to ask questions pertaining to this agreement. My signature on this form indicates that I have reviewed this Notice and that this Notice has been explained to me in a manner that I understand.

____

Patient or Person Authorized to Sign for Patient

Date____________________ Witness _____________________________________

In order to protect the privacy of you and your dependants, please list to whom, if anyone, we may inform about your general medical condition and diagnosis:

Name: Relationship:
____

Name:_________________________Relationship:_______________________________

Name:_________________________Relationship:_______________________________