

Ankle & Foot Center *of Charlotte*

ACKNOWLEDGEMENT FORM

Patient's Name: _____

Date of Birth ____/____/____
Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Signature: _____
(Patient or Authorized Representative)

Date: _____

Relationship to Patient: _____ Self _____ Spouse _____ Other

Reason Patient Unable/Unwilling to Sign:
