Elisabeth Potter, MD, PLLC

Notice of Privacy Practices

I acknowledge and agree that I have been provided a copy of the Notice of Privacy Practices for Elisabeth Potter, MD, PLLC that describes how my protected health information must be protected and my rights to access and control such information. I acknowledge and agree that I have reviewed the Notice of Privacy Practices in its entirety and been given the opportunity to ask any questions regarding the use of disclosure of my protected health information and my associated rights. I acknowledge and agree that I have had all of my questions answered to my satisfaction.

_____ _____

Patient Signature Date

_____

Print Name

For Office Use Only
We will make a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices provided to each patient. If a patient is unwilling or unable to sign the acknowledgment, the good faith efforts to obtain such acknowledgment and reason why the acknowledgment was not obtained must be documented.
Reason: