ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTCES

Dr. Peter Guhl, PLC & Assoc. reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices from Dr. Peter Guhl, PLC & Assoc.

I authorize the following individuals to obtain information regarding my care, including but not limited to my diagnosis, treatment and appointment dates and times.

NAME	**RELATIONSHIP**
_____	_____
_____	_____
_____	_____

I understand this acknowledgement and release will remain in effect until written notice is given to Dr. Peter Guhl, PLC & Assoc.

_____ _____

Signature Name of Patient(PRINT)

_____ _____

Signature of Patient Representative (required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Representative to patient

_____

Date

Revocation Date_____